91-03882/

WORKING TOGETHER FOR WOMEN'S HEALTH:

A FRAMEWORK FOR THE DEVELOPMENT OF POLICIES AND PROGRAMS

Prepared by
the Federal / Provincial / Territorial Working Group
on Women's Health

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April, 1990

TABLE OF CONTENTS

Executive Summary i

1. Introduction and Purpose 1

2. Women's Health Issues 3

A. An Overview

2.1 Mental Health 3
2.2 Reproductive Health 4
2.3 Violence Against Women 7
2.4 Chronic and Degenerative Health Conditions 9
2.5 Female Cancers 10
2.6 Women and Occupational Health 12
2.7 Women and Environmental Health 13
2.8 Nutrition 15
2.9 Fitness ("Active Living") 16

B. Special Population Groups 18
2.10 Women with Disabilities 18
2.11 Immigrant Women and Women of Colour 20
2.12 Native Women 22
2.13 Adolescent Girls 24
2.14 Senior Women 26

3. Key Challenges for Women's Health in Canada Today 29

3.1 The Social and Economic Realities of Women's Lives 29
3.2 Women's Relationships to the Health Care System 34

4. Strategies for Improving Women's Health 37

5. Recommendations for Change 42

6. Bibliography 44

7. Glossary 53

8. Appendices 55

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EXECUTIVE SUMMARY

Increasingly, over the past two decades in Canada, **women's health issues have been receiving more attention** by both the general public and government sectors. Women are learning more about their health, and medical policies are changing to consider women's needs. Policy-makers in different government jurisdictions are considering the importance of incorporating women's health issues into overall health policies.

In 1988, following a National Symposium on Changing Patterns of Health and Disease in Canadian Women, **the Conference of Deputy Ministers of Health established a Federal/ Provincial/ Territorial Working Group on Women's Health** to advise them on women's health matters. The group determined the need for a conceptual framework to assist in the understanding of women's health issues. This document **identifies those issues and outlines priorities for action** at the federal, provincial and territorial levels.

Women in Canada **live longer than men** and also **practise better health habits.** Over a lifetime, however, they **suffer more ill health** and **are more frequent users of the health care system.** In order to understand this seeming paradox, women's health must be studied in the context of the social realities of women's lives. This document assumes a **social view of health** such as that outlined by the World Health Organization. It also acknowledges the vital **importance of health promotion** in improving the overall health of Canadian women, as elaborated in the 1988 Health and Welfare document *Achieving Health for All.* Emphasis is also placed on the importance of **research** and **appropriate services for women.**

From the deliberations of the Working Group and the working papers prepared by its members, along with relevant external sources, a key list of women's health issues requiring attention has been identified. These issues have been raised in a variety of sectors and confirm those reflected in other national studies and the women's health literature. These include

* **women's mental health**: This has been identified as one of the most important of women's health issues in Canada today. Topics such as substance use and addictions, mental disorders more common in women, and the need for more gender-sensitive training of mental health professionals all fall within the scope of women's mental health issues.

* **reproductive health**: Women's reproductive health issues cover the full spectrum of a woman's reproductive years, from menstruation to menopause, pregnancy and childbirth, unintended pregnancies, sexually transmitted diseases, infertility, and new reproductive technologies.

* **violence against women**: This issue has been identified by a number of sources as a key women's health issue, covering incest, sexual abuse and harassment of women, physical and psychological violence by spouses and boyfriends, economic and psychological abuse of elderly women, and pornography. The importance of heightened sensitivity on the part of

health professionals and more and improved services for survivors of violence are identified.

* **chronic and degenerative health conditions**: This range of health problems tends to be found more commonly in women because of their longevity. Conditions include osteoporosis, respiratory and digestive disorders, depression and fatigue, and certain kinds of heart disease.

* **female cancers**: Breast, cervical and lung cancer are highlighted in particular, with breast and lung cancer being on the rise in the female population. Issues related to prevention, detection and treatment modalities are discussed.

* **occupational and environmental health**: The need for more research regarding the impact of these issues on women's health is noted. Evidence is given that the wide range of roles women carry out put them at risk for particular occupational and environmental health hazards.

* **nutrition**: Evidence indicates that Canadian women have poorer nutritional habits than men. They receive inadequate amounts of nutrients essential to their health, often as a result of a preoccupation with their weight, but also due to poverty and busy schedules.

* **active living**: (a term used by Fitness Canada to replace fitness and exercise) Canadian fitness measures show that women are less active than men, seen to be due in part to women's double workloads.

Health issues which are particular to **special population groups of women** are also discussed:

* **women with disabilities**: Key concerns include lack of or inappropriate access to facilities, misinformed and harmful societal attitudes towards those with disabilities, low self esteem, an increased experience of violence, and, above all, economic insecurity.

* **immigrant women and women of colour**: Women in these groups tend to experience barriers in receiving adequate health care due to lack of information in their language, discrimination against them, cultural insensitivity on the part of health care workers, and lack of services for those adjusting to a new culture.

* **Native women**: A distinction is made between the different needs of Native women in urban and remote settings. Particular health problems identified include respiratory diseases, eye and ear problems, diabetes, hypertension and an increased experience of violence in their lives. Problems associated with current childbirth practices in remote areas are discussed as well as the changes occurring as a result of a move to self-governance and a transfer of health services to a more local jurisdiction.

* **adolescent girls**: Issues discussed include stress, low self esteem, reproductive health problems (including sexually transmitted diseases and unintended pregnancies), the use of alcohol, drugs and tobacco, nutritional problems (including eating disorders), and poor

fitness levels.

* **senior women**: Particular note is made of the rate at which this sector of the population is growing and the link between poverty - at high rates with this age group - and ill health. Specific health issues identified include loss of function, depression and senile dementias, malnutrition, osteoporosis and the inappropriate and excessive use and abuse of prescribed and over-the-counter drugs.

The social and economic realities of women's lives are identified as having a particular impact on their health.

Women continue to experience **discrimination** on the basis of their sex. Canada's response in 1988 to the *United Nations' Convention on the Elimination of All Forms of Discrimination Against Women* outlines the nature of the forms of discrimination still experienced by Canadian women, and points to issues raised in this paper which affect women's health. These include economic vulnerability, violence and lack of influence in decision-making.

If, in addition to being female, one is disabled, Native, illiterate, immigrant, a woman of colour or of another **minority**, she is at an **increased risk for additional health problems**. Lack of appropriately targetted services and information, in addition to experiencing more overt discrimination in the health care system, can result in these groups receiving less than adequate care.

Women in Canada are **poorer** than men, making up the vast majority of low income lone parents in this country. A growing body of research now substantiates a **strong association between poverty and ill health.**

Women are more likely to **experience violence** than men. In Canada, one in every eight to ten women is battered by a partner or spouse and one in four women is sexually assaulted in her lifetime. Women suffer not only the physical consequences of violence but - more significant in terms of a long-term impact - considerable mental health effects.

Women **provide most unpaid and informal health care services** and also play a key role in **influencing the health behaviour of others**. This role includes not only the care of children, the elderly, disabled, sick and chronically ill family members, but also the task of organizing and co-ordinating the health-related activities and necessities of family members. This role takes its toll on women's physical and mental health and tends not to receive adequate societal recognition, economic or social support.

Increasingly, women **carry a double workload** - one in the paid work force and one in the home. With few exceptions, women continue to carry the bulk of the work load and responsibility for work done in the home. The **stress and fatigue** which ensue from this arrangement constitute an important women's health issue.

Women have a unique relationship to the health care system, partly because of their reproductive capacities but also because of their multiple roles.

Although women have a strong presence in numbers in the formal health care system, representing approximately 80% of all health care workers in Canada, they tend to be **stratified**

in the low-paying and low-status positions. The increasing presence of women in senior health administration positions as well as a greater presence on influential health care boards and committees is needed to ensure women's input into key policy decisions which will affect the entire community.

The problem of **gender bias in health research** and the **lack of priority given to women's health in research** are seen as having an impact on the overall health of women. This includes the under-representation of women in new drug and treatment modality trials, and the problems which can result in treatment when women's biological and hormonal differences are not accounted for in research. Certain women's health problems, such as those related specifically to childbearing, are seen to be given precedence over others, and are not reflective of the full spectrum of health care needs of Canadian women at all ages.

The shift to more community-based services which we are currently witnessing, as well as consumer involvement in designing and delivering these services, promises to more effectively meet women's health care needs.

In response to the challenges facing women's health, a series of **strategies for improving women's health are presented**. As noted in the Canada Health Act, the primary objective of Canadian health care policy is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers". In light of this directive, and borrowing from the language of *Achieving Health for All*, strategies are proposed to:

1) **Foster the Participation of Women**

Women of all ages, races, economic levels, religions, languages, cultures, literacy levels, abilities and regions of Canada **must be involved in the creation and implementation of programs, policies and services** related to their health. Women must be consulted as to their health care needs and welcomed as partners in decisions regarding their health care. Women's role as "health guardians in the home" requires further acknowledgement.

2) **Build and Strengthen Appropriate Health Services for Women**

All Canadian women require **access** to appropriate and affordable quality health services as well as **information and education** on how to maintain their health and well-being. Current epidemiological research does not put sufficient emphasis on the chronic and debilitating conditions which characterize many women's lives, nor does it consider the extent to which women's double workloads and their roles as child-bearers and child-raisers directly affects many aspects of their health. Only when these shortcomings in current research are addressed will we be able to sufficiently develop and strengthen appropriate health services for women. **Focal points** for women's health at the federal, provincial and territorial levels must also be developed and strengthened.

3) **Co-ordinate Healthy Public Policy**

All sectors which influence women's physical and mental health - **health, housing, employment, social services, justice and education - must work together to create healthy public policies**. Examples are provided of ways in which these various sectors can work to improve women's health and a point is made of the co-ordinating role which the health sector can play in achieving these changes.

Canada has played an active role in the development of women's health policy. Individual provinces have also shown leadership in women's health through the establishment of breast and cervical screening programs, dedicated women's health bureaus and community and hospital-based women's health centres. The federal Department of Health and Welfare has long shown a commitment to women's health issues through the national and international work of the Office of the Senior Adviser Status of Women, as well as its community-based funding programs of the Health Promotion Branch.

As a result of the process of examination of the challenges facing women's health and through the work of devising strategies for change, the Working Group created a series of recommendations which are intended to bring about positive change for the health of Canadian women.

RECOMMENDATIONS
OF THE
FEDERAL / PROVINCIAL / TERRITORIAL
WORKING GROUP ON WOMEN'S HEALTH

In order to improve the health and well-being of all Canadian women, the Working Group recommends that:

1. **EACH JURISDICTION ADOPT THE FOLLOWING GUIDING PRINCIPLES IN THE DEVELOPMENT OF POLICIES AND PROGRAMS ON WOMEN'S HEALTH:**

   A. ADDRESS THE SOCIAL AND ECONOMIC INEQUITIES OF WOMEN'S LIVES

   - women are poorer than men
   - women experience more violence
   - women experience discrimination;

   B. FOSTER GREATER PARTICIPATION AND EFFECTIVE REPRESENTATION IN PLANNING AND PROGRAM DELIVERY

   - women constitute 80% of workers in the paid health care sector, but few of the decision makers;

   C. RECOGNIZE AND SUPPORT WOMEN'S ROLES AS CAREGIVERS

   - women provide most formal and informal health care services
   - women have a double workload in the home and paid workforce;

   D. FOSTER A COMPREHENSIVE, INTEGRATED MODEL OF HEALTH SERVICES FOR WOMEN

   - the current health care system (acute, episodic, fragmented care) is inappropriate for women's health needs
   - a greater emphasis on health promotion and disease prevention is essential, and

   E. PRESERVE AND RESPECT THE DIVERSITY OF WOMEN

   - women with disabilities, indigenous and immigrant women as well as

women of colour experience multiple barriers to achieving health.

2. **EACH JURISDICTION ESTABLISH OR STRENGTHEN A MECHANISM WHICH IS ACCOUNTABLE FOR WOMEN'S HEALTH THAT HAS THE ADEQUATE MANDATE, AUTHORITY AND RESOURCES TO**

   A. **DEVELOP A FIVE-YEAR ACTION PLAN (1991 - 1996) BASED ON THE STRATEGIES DESCRIBED IN THIS REPORT, AND**

   B. **FACILITATE THE DEVELOPMENT, CO-ORDINATION AND IMPLEMENTATION OF POLICIES AND PROGRAMS.**

3. **EACH JURISDICTION RECOGNIZE WOMEN'S GROUPS AND VOLUNTARY ORGANIZATIONS AS ESSENTIAL PARTNERS AND COLLABORATE WITH THEM IN PLANNING AND PROVIDING SERVICES TO WOMEN.**

4. **EACH JURISDICTION ENSURE CONTINUING REPRESENTATION AND COMMITMENT TO INTER-JURISDICTIONAL COLLABORATION IN**

   A. **ADDRESSING WOMEN'S HEALTH CONCERNS, AND**

   B. **MONITORING THE IMPLEMENTATION OF THE STRATEGIES AND RECOMMENDATIONS IN THIS REPORT.**

1. INTRODUCTION AND PURPOSE

Throughout the 1970s and 80s, a growing awareness of issues related to women's health has surfaced in Canada. This awareness and actions resulting from it have occurred at both the community level and within government. Some women are learning more about their health and are better understanding their physiology as a result of an abundance of information now available to them. Medical and health care policies are changing to reflect a better understanding of women's health care needs and the need for health promotion efforts directed at women. Progress has occurred on many levels, but much change is still needed.

This document takes a closer look at some of the key health issues facing women in Canada today and at the key challenges before us if we are to improve the level of health of Canadian women. In so doing, the document adopts the World Health Organization's definition of health, that of "...a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity ". The main principles of health promotion as outlined in Canada's framework for health promotion also provided direction.[1]

The present discussion of women's health care needs is taking place against a backdrop of heightened public attention to a much broader range of health issues including the growing cost of health care for Canadians, the role of technology in health care, and the future distribution of health care resources at a time when the older population is growing. This discussion is also occurring at a time of heightened awareness about the everyday realities of the lives of Canadian women. Increasingly Canadians are recognizing the importance of addressing women's social and economic inequities through policies which deal with such issues as equal pay, child care and improved services for battered women. Viewing women's health in this larger social context is consistent with the orientation of *Achieving Health for All*.

Improvements in the status of Canadian women and their health have been assisted by the efforts of the United Nations Decade for Women (1975 to 1985) which culminated in a world conference held in Nairobi in 1985. Throughout the decade and at the international conference, women's health was continually identified as an area requiring particular attention. (See Appendix A, *The Nairobi Forward-Looking Strategies for the Advancement of Women to the Year 2000, Extracts of the Health-Related Paragraphs*, on page 58.)

In 1986, the Department of Health and Welfare conducted a key informant survey on

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[1] *Achieving Health For All: A Framework for Health Promotion*. Ottawa: Health and Welfare Canada. 1986.

women's health issues across Canada[2]. The survey revealed that key health issues for women in Canada include mental health, reproductive health, violence against women, reproductive disorders, occupational and environmental health, nutrition and fitness, and chronic medical conditions. Factors underlying women's health issues, groups at special risk and factors which facilitate health were also identified.

In 1988, the Department of Health and Welfare convened a National Symposium on Changing Patterns of Health and Disease in Canadian Women held in Ottawa in April. The Symposium was one of the major initiatives of the Office of the Senior Adviser, Status of Women's "Plan of Action" (1985-90) based on the Nairobi Forward-Looking Strategies. Again, from this Symposium, a series of Forward-Looking Strategies emerged which outlined some of the key areas in women's health needing the attention of various jurisdictions. These strategies fall under the headings of Healthy Public Policy, Appropriate Health Services, and the Enhancement of Coping, Caring and Control.

Another important outcome following the Symposium was a proposal to the Conference of Deputy Ministers of Health to create a Federal / Provincial / Territorial Working Group on Women's Health, and the acceptance of that proposal by the Conference of Deputies. The Working Group was mandated to provide advice on women's health issues to the Conference of Deputy Ministers. Early in its history, the working group determined the need for a working document on women's health, the purpose of which would be **to provide a conceptual framework for understanding and promoting women's health, to identify key women's health issues and concerns and to identify priorities for action both nationally and at provincial and territorial levels.**

This paper, which builds on previous documents addressing women's health policy[3], examines the challenges and strategies for effective change in women's health in Canada.[4]

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[2] *Issues and Priorities for Women's Health in Canada: A Key Informant Survey*. Health and Welfare Canada, November, 1988.

[3] Report of the Public Health Service Task Force on Women's Health Issues (U.S., 1978), The Nairobi Forward-Looking Strategies for the Advancement of Women (1985) (Extracts from the Health-Related Paragraphs, 1988); Regional Forward-Looking Strategies on Women, Health and Development, Pan-American Health Organization (1986); Forward-Looking Strategies from the National Symposium on Changing Patterns of Health and Disease in Canadian Women, Ottawa, (1988); National Women's Health Policy: Advancing Women's Health in Australia (1989); Women's Health Resolutions from the Forty-Second World Health Assembly (1989).

[4] Certain terms and phrases used throughout the document are defined in the Glossary on page 53.

2. WOMEN'S HEALTH ISSUES

A. An Overview

Social and economic variables in women's lives can strongly influence their health and make their health care needs quite different from those of men. In this section, some of the specific health care issues which Canadian women face today are discussed.

2.1 Mental Health

Mental health issues have been identified by women across Canada as one of the most pressing of women's health issues. A key informant survey conducted by Health and Welfare Canada in 1986[5] identified mental health as a major area of concern. The Canadian Mental Health Association's report of 1987, *Women and Mental Health in Canada: Strategies for Change*, argued that mental health is closely linked to the social and economic conditions of women's lives. The socially disadvantaged position of women, coupled with the tendency of some mental health professionals to stereotype women's problems with little reference to the context of their lives, has led to a situation where some services available to women are inadequate and inappropriate.

The most frequently diagnosed mental illnesses for women in Canada are depression, anxiety disorders, "borderline" personality disorders, and eating disorders.[6] Women have increasingly questioned the interpretation of many such "illnesses" in the traditional psychiatric literature which tends to view any departure from expected role behaviours as "sickness". On the other hand, the real issues confronting many Canadian women, such as trauma resulting from violence (both wife abuse and sexual abuse) and the stress of work and family responsibilities, have not received the attention many feel they deserve. Also, the illnesses associated with workplace stress, or the difficulties faced by adolescent women in the process of growing up within a system which puts undue emphasis on thinness and physical appearance, have not received the careful consideration they deserve within the mental health system.

Women's practices with respect to substance use warrant further investigation. While fewer women than men consume alcohol in excess[7], women are prescribed mood-altering drugs at

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[5] *Issues and Priorities for Women's Health in Canada: A Key Informant Survey*. Ottawa: Health and Welfare Canada. 1988.

[6] Canada Health Survey, Health and Welfare Canada, and Statistics Canada, unpublished data used in *Women in Canada: A Statistical Report* (1985).

[7] A recent study from the Addiction Research Foundation in Ontario, however, indicates that young women (18 to 29) are approaching men in their rates of alcohol and drug consumption. (*Globe and Mail*, November 24, 1989)

significantly higher rates than men[8]. The issue of over-prescribing to older women in particular has been raised.[9] Although fewer women than men smoke[10], the rate at which women are taking up smoking is greater than that for men. Women start and quit smoking for reasons specific to their sex.[11]

Traditional therapy has tended to identify these problems as due to some psychopathology present in the woman, and has largely ignored the context of women's lives. This is particularly true with regard to the social origins of depression. Feminist counsellors, though frequently not covered by provincial health insurance plans, emphasize the importance of gender role analysis, and assist women to analyze the situations in their lives which are leading to emotional difficulties for them. Increasingly, women are pointing to the need in the training of different mental health professionals[12] for a broader understanding of sex role differences, as well as the need for broadened health insurance coverage to a greater range of practitioners.

2.2 Reproductive Health

Reproductive issues have been the mainstay of the women's health movement and are a major reason for women's use of the health care system. Women have unique health care needs and a unique relationship to the health care system because of their childbearing role. However, reproductive health is a broader issue than childbearing. Reproductive health integrates the health of a woman's reproductive system across the entire life span, the ability to conceive and bear healthy children, the ability to control one's own fertility, and the need to prevent reproductive cancers. Major and interrelated areas of concern for women include:

i) ***Unintended Pregnancies***

A significant number of women, especially adolescents and young women, experience unintended pregnancies which have long-term social, economic and health consequences. Early teenage childbearing is a particular concern as it often begins a cycle of poverty and dependence on social assistance. Effective, safe and convenient methods of contraception, access to contraceptive counselling and clinical services, and access to early and safe abortions are key women's health issues.

ii) ***Sexually Transmitted Diseases*** (STD's)

The prevention of STD's is crucial to improving the reproductive health status of women.

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[8] Health Promotion Survey, 1985 (*Selected Data*, Table 22).

[9] Harding, Jim. "Mood-modifiers and elderly women in Canada: The medicalization of poverty", in K.McDonnell, ed. *Adverse Effects: Women and the Pharmaceutical Industry*. Toronto: Women's Press. 1986.

[10] In Québec, where the proportion of the population who smoke is 25% higher than the Canadian average, the gap between male and female rates is less significant: 31% of women and 35% of men smoke. (Government du Québec, April, 1989)

[11] Greaves, 1987.

[12] Including psychiatrists, psychologists, psychotherapists, and social workers.

Two common STD's, gonorrhoea and chlamydia (the latter now the most common STD in Canada), if untreated, can lead to infertility. Certain types of Human Papilloma Virus, another sexually transmitted disease said to be found in roughly 30% of North American women, have also been associated with a risk of developing cervical cancer.

Between 4% and 6% of Canadian adult cases of AIDS have involved women. Women who are involved in injection drug use, intercourse with multiple and unknown partners, and intercourse with infected men are all at risk for HIV infection. HIV-infected women and those with AIDS can infect their unborn children during pregnancy or at childbirth.

iii) Infertility

The effect of STD's on future fertility is a major concern, especially for sexually active adolescents who are less likely to protect themselves from infection. Reproductive health hazards in the workplace have received increasing attention as the effects of various physical, chemical and biological agents on the reproductive systems of both women and men are often unknown. Concern has been raised about the disproportionately low funding for research on the causes and prevention of infertility compared to the level of funding for new reproductive technologies aimed at treating fertility problems.[13] The Québec government has recently called for its provincial research bodies to "make room for research into the cause and treatment of infertility as well as the means of contraception, their effectiveness, their effect on fertility and infertility, and alternatives to premature voluntary sterilization".[14]

iv) New Reproductive Technologies (NRT's)

There is an increasing demand for what appears to be a costly technology with a relatively low success rate. The use of NRT's, including in vitro fertilization, embryo transfer, artificial insemination and prenatal diagnostic techniques, has raised ethical, social and health questions. Concern has also been expressed about the coverage of NRT costs by health insurance plans, as well as issues relating to the legal rights and status of each participant. In response to a high degree of public and professional concern about the social, ethical, legal, and economic implications of the new reproductive technologies, the federal government appointed a Royal Commission on New Reproductive Technologies in October of 1989. One of the broader aspects of its mandate is to examine the implications of new reproductive technologies on women's reproductive health and well-being, as well as "to provide advice that will help to influence the regulation of reproductive technologies in Canada"[15]. The Commission is expected to submit a report to the federal government by October of 1991.

v) Pregnancy and Childbirth

Although Canadians have seen an improvement in maternal, infant and child mortality rates

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[13] Williams, 1986.

[14] Gouvernement du Québec, Ministère de la Santé et des Services sociaux, April 1989.

[15] Press release, Office of the Prime Minister, October 25, 1989.

for both Native[16] and non-Native women in the past few decades, a number of unresolved issues related to pregnancy and childbirth remain. Canada has one of the highest Cesarean section rates in the developed world. Concern has been raised about the appropriateness of this procedure in many cases. Emphasis has been on healthy outcome[17] and alternative methods of care such as midwifery. A number of provinces have undertaken measures towards the eventual legalization of midwifery. Ontario expects to see the profession accorded legal status within the next two years. Inadequate nutrition and inadequate prenatal education and support services are still negatively affecting the perinatal outcome of many low income, adolescent and Native women across Canada. Particular problems in pregnancy also have been noted in women exposed to DES (diethylstilbestrol) in utero.

vi) Menopause

With a rapidly aging population, more attention is being paid to the concerns of women at the end of their reproductive years. For many, it is a life experience which coincides with other major life changes, sometimes compounding any negative symptoms of the menopause. Concern has been raised that women are receiving contradictory information about hormonal therapies related to menopause and, indeed, there is no consensus in the literature about the risks and benefits associated with using hormone replacement therapy.[18] Issues for women experiencing premature or surgical menopause must be distinguished from those for women experiencing natural menopause.

Sexual health must be actively promoted as a component of a healthy lifestyle. This requires viewing sexual health holistically, through an "integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love".[19] Nova Scotia has recognized the critical nature of sexual health and healthy lifestyles with the development of Sexuality Education Resource Nurse (SERN) Program. As well, reproductive health nurses are attached to several regional health units in Newfoundland.

It is also important to consider that women's reproductive health can have a direct impact

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[16] The practice of flying Native women out of their communities in order to give birth has been seen as a major factor in improving infant and maternal mortality rates (Epp, 1988), although it is not without its psychological consequences (*Report of the Task Force on the Implementation of Midwifery in Ontario* [1987], submission to the Task Force by Patricia Kaufert and John D. O'Neil).

[17] This philosophy was summarized in an address by Abby Lippman at the National Symposium on Changing Patterns of Health and Disease in Canadian Women (1988): "Our philosophy should *not* be that pregnancy is normal only in retrospect, but, that most pregnancies are normal, although we must be prepared for deviations. This will entail re-orienting obstetric care to include...providing women with information about their bodies and changes to be expected during pregnancy and delivery...in ways that respect and take appropriate account of individual socio-economic and educational variations, identifying occupational risk factors and establishing work and living conditions that will guarantee and maintain the health of pregnant women...providing the opportunity for pregnant women to be actively involved in decision-making about pregnancy and delivery".

[18] Cobb, 1989.

[19] World Health Organization. *Education and Treatment in Human Sexuality : The Training of Health Professionals.* Report of a WHO consultation. Technical Report Series 572. Geneva: 1975.

on other facets of women's health. Consider, for example, the mental health issues associated with pregnancy, abortion, the post-partum period, hysterectomy and infertility or the important relationship between pregnancy and diabetes. These linkages serve as examples of why reproductive health must be looked at in the context of women's overall health.

Major barriers to women's reproductive health include inaccessible services and insufficient information in all parts of Canada. Services must address physical as well as emotional needs and be age-relevant, as well as culturally and linguistically appropriate to the local community; they must also address women's reproductive health needs in the context of their social circumstances. Groups at risk of receiving less than adequate care include adolescents, low-income women, rural women, disabled women, Native women, immigrant women and women of colour.

2.3 Violence Against Women

The *Nairobi Forward-Looking Strategies* (paragraph 288) stated that, in light of the increase of violence against women, affirmation of the dignity of women needed to be considered an action priority. It further recommended that a broad range of assistance measures for survivors, public consciousness raising, appropriate policies, programs and legislation, preventive action and aggressor reduction were all required.

Violence against women takes the form of incest involving young girls, sexual abuse and harassment of women, physical and psychological violence by spouses, economic and psychological abuse of elderly women and pornography. Health and Welfare Canada's *Key Informant Survey* revealed that violence against women was identified as the second priority for intervention for close to three quarters of the informants surveyed. Awareness of the extent of this problem has been largely aided by efforts of the women's movement. The most recent statistics indicate that one in eight Canadian women will experience spousal violence in her lifetime and one in five will be the victim of sexual assault.

Activity at different government levels has focused heavily on issues related to wife assault, but attention to sexual assault is beginning to surface. This is taking the form of public awareness campaigns and, in some places, inter-departmental committees looking at different aspects of the issue.

All forms of violence against women can leave significant scars, sometimes acute and sometimes long-term, on women's health and well-being. The incidence of mental health problems related to sexual abuse during childhood, the focus of workshops during the most recent Canadian Mental Health Association conference on women and mental health (Banff, 1989), clearly illustrates the significance of the long-term effects of violence.

In a study conducted for the National Institute of Mental Health in the United States in 1981[20], investigators found that 21% of all women who use emergency room services in hospitals have been battered, but this often goes undetected by medical staff. Some hospitals in Canada have

[20] Stark et al, 1981.

taken their cue from community-based women's services for survivors of sexual assault and have formed support networks to insure that survivors have access to the required forensic medical services adapted to their situation. The Ontario Medical Association, the British Columbia Medical Association, and the Ordre des infirmières du Québec have recognized this service gap and are successfully implementing protocols for emergency room procedures with battered women.[21] Nonetheless, a great deal remains to be done for the health care system to adequately respond to the needs of a clientele affected by violence.

Additional initiatives have been undertaken at the federal level to combat the prevalence of violence against women. The Federal/Provincial/Territorial Working Group on Battered Women submitted its report to the Ministers Responsible for the Status of Women in June, 1986. The Canadian Advisory Council on the Status of Women's *Battered Women in Canada, A Vicious Circle* (1980) and *In the Name of Love...Preventing Spousal Violence* (1987) have been additional and important contributions. Other initiatives have included the coordination of activities of the Family Violence Prevention Division of the Department of Health and Welfare, such as their June 1989 National Forum on Family Violence in Canada, as well as modifications to the Canadian Criminal Code.

Historically, women have worked at the issue of violence against women at the grassroots level for many years. In addition to providing information and a safe haven for women who have been abused or assaulted, survivors have supported each other through informal means in a variety of ways for as long as this has been documented in history and, undoubtedly, beyond. In the past few decades, groups and individuals have worked tirelessly with government to fund and improve services and to raise awareness. For their part, the provinces have developed programs and services in the area of violence against women and have provided operational support for close to 300 shelters for battered women and support groups for survivors of sexual assault. British Columbia has established an Institute on Family Violence.

Improving the awareness of health professionals of both sexes on this issue, along with systematic training regarding detection and the health implications of violence against women are a priority. These health implications include such issues as a high incidence of addictions and eating disorders amongst survivors, pregnancy as a vulnerable period for the cycle of assault to begin, and depression as a coping mechanism and a chronic reaction for women. All of these issues require further research. In Newfoundland, three-day multidisciplinary workshops on wife battering are being conducted through the Public Service Commission to give professionals who encounter abused women in their work a better understanding of the scope of the problem and an effective response to the needs of women and their children. The organization of services adapted to survivors' needs, in particular to disadvantaged groups such as Native women[22], requires close co-operation with community organizations already committed to the campaign against violence against women.

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[21] Bain, 1989.

[22] Earlier this year, the Ontario Native Women's Association released a report indicating that eight out of ten Indian and Métis women have suffered some form of abuse, mostly at the hands of their spouses. This high rate of violence was blamed on "poverty, poor social conditions and political frustration in the fight for self-governance". (*Toronto Star*, January 19, 1990) The report calls for "healing lodges" for the female survivors and treatment programs for batterers "designed and staffed by aboriginal persons".

2.4 Chronic and Degenerative Health Conditions

The prevalence and impact of chronic and degenerative conditions, such as sensory impairment, cardiovascular disease, musculoskeletal conditions and incontinence, increase with age, particularly during the more senior years. Since women live longer than men in Canada and are reaching the ranks of middle old (75 to 84 years) and very old (85 years and over) at a growing rate, they are experiencing the consequences of these conditions in greater numbers than men and in numbers unprecedented in history.

Slow and insidious onset, difficulty in diagnosis, vagueness of symptoms, mysterious remissions and exacerbations are all characteristic of chronic conditions. These can lead to multiple referrals to specialists and, sometimes, excessive and inappropriate prescription of drugs. While these issues are important to all health care consumers, providers and decision makers, they are of particular concern to women because they suffer from more chronic and degenerative conditions than men and make up the majority of caregivers in this area of health care.

A number of degenerative and chronic conditions are more common among women than men, even for individuals of the same age. Women report higher rates than men of some crippling musculoskeletal conditions such as arthritis and rheumatism, and also have higher rates of osteoporosis, respiratory and digestive disorders, depression and fatigue. Older women are 4 times more likely than older men to have foot problems, usually as a result of improper or restrictive footwear worn in their younger years[23]. Lupus, an auto-immune disease characterized by an inflammatory reaction in many organs of the body, is far more common in women than in men. Roughly 90% of lupus patients in Canada are women and predominantly in their child-bearing years.

Dr. Donald Beanlands noted in his address at the National Symposium (1988) that women do not develop heart disease at the same rate as men, but develop certain kinds of heart disease more commonly and later in life than men. Even though heart disease is rare in the younger age groups, it is relatively more common in females who combine cigarette smoking and use of contraceptive pills. Women have higher mortality from stroke at younger ages than do men. Excess weight has been found to increase the risk of developing health problems including heart disease, particularly among women aged 50 to 59.[24]

Poverty and poor nutrition habits are increasingly being associated with many health problems, including a variety of chronic and degenerative conditions. Women have higher rates of poverty than men (particularly in their senior years) and women tend to have higher rates of under-nutrition (both in terms of calories and adequate nutrients). Both of these factors put women at higher risk for increasing degenerative and chronic conditions.

A health system which manages chronic and degenerative conditions well would include services oriented to the management of health problems on a long-term basis rather than over-

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[23] Ford, 1987.

[24] *Canadian Guidelines for Healthy Weights: Report of an Expert Group Convened by the Health Promotion Directorate, Health Services and Promotion.* Minister of Supply and Services, Cat # 39-134/1989E.

reliance on episodic treatment of acute events. It would also include an emphasis on home care and support services, raising the awareness and coping skills of those with the conditions rather than relying on professional experts providing treatments to uninformed patients. Individuals may expect and even come to depend on chemical and technological measures to alleviate problems, if these measures appear to be the best available option. However, the current bias towards pharmaceutical and other medical and technological measures, rather than lifestyle regimes for the long-term management of chronic and degenerative conditions is increased by current funding and reimbursement plans which more readily pay for drugs and medical treatments than provide effective lifestyle management programs. Review of this policy approach is warranted at all levels.

2.5 Female Cancers

Health and Welfare's Key Informant Survey on Issues and Priorities for Women's Health in Canada (1986) identified female cancers, and in particular breast cancer, as a key health issue for women. The overall incidence of all cancers in women increased by 23% between 1976 and 1987, with the most significant increase occurring in lung cancer.[25] According to further Statistics Canada data, the only three causes of death which increased for women in the ten-year period from 1976 to 1986 were lung cancer (94%), breast cancer (7.4%) and all malignant neoplasms (6.3%).[26]

Breast cancer is the most common type of cancer in women, accounting for one in twenty female deaths. One in ten women will develop breast cancer in her lifetime, with it being detected in approximately 7,000 women across Canada each year. Standardized data from Statistics Canada indicate that the incidence of breast cancer has increased across Canada since 1980. The person years of life lost from breast cancer exceed that from lung cancer by more than 45%.[27] Little substantive information is available regarding risk factors, although research looking at the relationship of diet to the development of breast cancer is under way in Ontario and British Columbia. The disease is particularly prevalent in women over 65, with this age group almost three times more likely to develop this form of cancer.

The incidence and mortality rates for cervical cancer, in contrast with breast, lung and skin cancer, do not appear to be on the rise, although experts agree that incidence rates are difficult to interpret.[28] For example, over-reporting of cancer of the cervix occurred for some years in one province (British Columbia) and under-reporting occurred in another (Ontario). Some medical literature indicates a link between cervical cancer and sexual activity (particularly with multiple partners) while other researchers have found that not having ever had a Pap smear is a more important variable. Smoking, directly related to cancer of the lungs, has been shown to be a contributing factor in cervical cancer, pointing to the need for increased information to younger

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[25] *Selected Data*, Table 9.

[26] ibid, Table 5.

[27] *Health Reports, Vol.1, No.1, 1989.*

[28] Clarke, E.A. and Hilditch. "Problems in determining the incidence of cervical cancer". *Canadian Medical Association Journal*. Vol. 129, 1983.

women taking up smoking. The incidence of cervical cancer amongst Native women is four times higher than for the general female population.[29] In British Columbia, for example, where a mechanism is in place for gathering such information, Native women undergo Pap testing far less frequently than non-Native women, suggesting a need for outreach services for this group.

Effective screening, early detection and timely and appropriate treatment are key factors in the management of breast and cervical cancer. The Canadian Task Force on Cervical Screening has identified the issue of false negatives in Pap smears as a problem in about 10% of cases.[30] This suggests the need for centralized Pap screening, such as the Cervical Cytology Screening Program in British Columbia, to assure quality control of test procedures. A workshop on cervical cancer held in Ottawa in November of 1989 and sponsored by the Department of Health and Welfare, the Canadian Cancer Society and the National Cancer Institute of Canada recommended that "governments should encourage and support the development of organized cervical cytology screening programs designed to reduce the morbidity and mortality of cancer of the cervix".

Organized screening programs for breast cancer are a relatively recent development in Canada. British Columbia opened its first screening centre in 1988, and intends to establish dedicated, as well as mobile units, throughout the province over the next few years. Ontario announced a similar program in May of 1989, with delivery in dedicated centres, satellite centres and affiliated centres throughout the province. Nova Scotia is currently developing regional screening centres and Manitoba is also presently considering a breast cancer screening program. In the spring of 1989, the Alberta government announced their commitment to establish a breast cancer screening program with funds for the development and implementation of such a program.

Treatment modalities have increased in recent years for both breast and cervical cancer. For example, lumpectomies are increasingly replacing the more disfiguring mastectomies in breast cancer patients. Cryosurgery and laser surgery are used for the cervical dysplasias found at the time of screening and these techniques have reduced the need for cone biopsies and more extensive surgery. A proportion of these lesions will become invasive cervical cancer, the treatment for which is generally hysterectomy for the localized lesions (i.e. Stage I) and radiotherapy for the more advanced cancer. Options vary considerably across the country with more being available to women in large urban centres. The psychosocial aspects of these cancers, in particular coping with the aftermath of disfiguring or removal surgery for specific female cancers, require more attention.

Colorectal cancer, although slightly higher in men than women, has also risen by 21% over the period from 1976 to 1987.[31] Although a high intake of fibre is seen as a preventive measure for the development of colorectal cancer and other gastrointestinal diseases, more research is needed into sex differences in the reaction to the use of fibre, which may interfere with calcium absorption in women.

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[29] Threlfall, W.J., Gallagher, R.P. et al, "Cancer patterns in British Columbia Native Indians". *British Columbia Medical Journal*. 1986; 28:7, p. 508-510.

[30] Sangster, John F., & Gerace, Toula. "Management of cervical dysplasia". *Canadian Family Physician*. Vol.32, March 1986, pp 565-7.

[31] Vital Statistics Section, Health Division, Statistics Canada. "Standardized cancer incidence rates by selected sites and sex, 1976-1987".

Although numbers are small, some Canadian women have developed a rare form of cervical and vaginal cancer - clear cell adenocarcinoma - as a result of their mother's ingestion of DES (diethylstilbestrol) in pregnancy. DES is reported to have been prescribed to thousands of Canadian women between 1940 and 1971.

As Canada's population ages and women enter the age range where female cancers are more prevalent, the need for increased education, clinical and emotional support services and more research becomes increasingly evident.

2.6 Women and Occupational Health

Occupational health is an underdeveloped field in Canada[32]. Very few studies have included or focused on women workers. While the occupational health concerns of women are similar to those of men, involving the same physical, biological and chemical hazards in the workplace, the specific biological functions of women, namely, pregnancy, lactation and menstruation, may require particular attention. Research and writing on women's occupational health have focused on reproductive outcome; however, it can be argued that it has been so at the expense of looking more closely at reproductive outcomes based on male exposure.

While virtually all the prohibitive or exclusionary "protective" legislation has been revoked or extended to ensure protection of all workers, the federal Women's Bureau of Labour Canada notes "the increasing evidence of company policies excluding women from certain jobs involving potential exposure to hazardous substances". (1989) Notions of "women of childbearing age" are inconsistently applied to different substances (for example, lead, ionizing radiation, benzene), and ignore the contribution of men to healthy embryo formation. Researchers at the Université du Québec in Montréal found that sex-specific differences in working conditions, not biology, explained the differences in health complaints in a study of female and male workers at nine poultry processing plants.[33]

In addition to a focus on reproductive health concerns, the Nairobi Forward-Looking Strategies stipulate that "efforts should be directed to the health impact of new technologies and the harmonization of work and family responsibilities."[34]

It has been argued that the study of women's occupational health must cover a wider range of issues. Paltiel (1989) has noted that "the health of women depends upon the context of their sectoral and occupational concentration, their physical, biological and chemical environments, the condition of their work, the processes in which they are engaged, and the amount of control they have over their work environments, conditions and processes." She adds that "the psychosocial environments at work and at home are also factors, as is the gender and age-based allocation of

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[32] This is in particular contrast to countries like Sweden with its highly developed legislation and public awareness on occupational health issues.

[33] Mergler, 1984.

[34] *Nairobi Forward-Looking Strategies for the Advancement of Women to the Year 2000*, July 1985, paragraph 162.

status, role and rewards [since] women bear the major responsibility for family members, within and outside their households, as well as their household responsibilities".[35]

Potential hazards common to many women's jobs include:

* sexual harassment
* job insecurity
* subordinate status and lack of control
* the double load of work and family responsibilities
* quick movement of heavy loads
* repetitive work with the hands
* prolonged standing
* machine pacing, immobility, eyestrain
* lifting
* indoor air pollution

Nearly 80% of workers in the health sector are women.[36] Hunt (1979) calls the work environments of the large numbers of women in hospitals and biology and chemical laboratories "unhealthy places of employment". Yassi (1989) at the National Symposium on Changing Patterns of Health and Disease in Canadian Women, emphasized burnout as an increasingly prevalent concern, causing large numbers of nurses, teachers, and daycare and social workers to leave their jobs. Nurses everywhere are at risk, not only from exposure to toxic substances, but to stress and physical abuse from patients. Nurses' easy access to addictive drugs also puts them at additional risk.

A wide range of worksite health promotion opportunities exist, including cancer control, diabetes and osteoporosis control and education, blood pressure and obesity reduction, family violence prevention and control, age and sex-appropriate fitness and nutrition programs, and smoking cessation and substance abuse programs designed for women.

2.7 Women and Environmental Health

Environmental health is defined as "the aspect of public health concerned with all the factors, circumstances and conditions in the environment or surroundings of humans that can exert an influence on human health and well-being".[37] From Rachel Carson's *Silent Spring* to Gro Harlem-Brundtland's *Our Common Future*, women have sounded the alarm globally to the deterioration of the environment and have proposed viable solutions to the elimination of

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[35] Paltiel, F.L. 1989.

[36] Statistics Canada, Women Health Providers by Occupation (table), Statistics Canada, 1986 Census.

[37] Last, John M., (1987), p.131.

environmental hazards.[38] The Nairobi Forward-Looking Strategies proposed the following guidelines for environmental health:

> "Efforts to improve sanitary conditions, including drinking water supplies, in all communities should be strengthened, especially in urban slums and squatter settlements and in rural areas, with due regard to relevant environmental factors. These efforts should be extended to include improvements of the home and work environment and should be effected with the participation of women at all levels of the planning and implementation process".[39]

Although there has been no detailed analysis of the effects of environmental policies on women, some specific health issues have been studied. Increased insulation of homes for energy conservation purposes may lead to a greater accumulation of indoor air pollution from scented cleaning and laundry products, refrigerants and personal care products, art and craft materials, wood burning and gas stoves and pest control substances.[40] Gorham et al (1989) found strong positive associations between levels of acid rain-forming pollution (acid haze) and mortality rates for breast and colon cancer in 20 Canadian cities.[41] PCBs, which have been restricted since 1976-77, appear to have changed little in residue level in human tissue (breast milk, adipose tissue and blood) between 1976 and 1984.[42] A 1988 survey of Inuit women on the east coast of Hudson Bay found an average of 3.6 parts per million in breast milk - among the highest levels ever reported.[43]

The roles and tasks of women as caregivers, workers, parents, consumers, food preparers, health providers and childbearers can give rise to serious concerns about environmental exposure as a result of close proximity to high-voltage power lines, exposure to herbicides and pesticides and the confounding effects associated with exposure to a multiplicity of substances. Rural women have additional concerns related to long-term effects of daily exposure to an increasing number of chemicals on their farms. Native women can be faced with environmental concerns as fundamental as a lack of clean water and inadequate or non-existent sewage disposal.

Policy development to address environmental issues has the potential to enhance primary prevention of disease. Sex-specific research on the effects of environmental agents on individuals and specific target populations is needed. Better information is needed regarding the presence of

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[38] National women's groups as diverse as the Canadian Federation of Business and Professional Women's Clubs, the National Council of Women of Canada, the Catholic Women's League, the National Action Committee on the Status of Women, the Canadian Federation of University Women and the Federated Women's Institutes of Canada have all expressed concern, and in some cases sought federal action, on environmental health issues.

[39] *Nairobi Forward-Looking Strategies for the Advancement of Women to the Year 2000*, July 1985. Paragraph 225.

[40] Small, B. and P.Eng (1989), p 2-7.

[41] Gorham et al, p. 96-100.

[42] Frank, R. et al (1988), p 150-158.

[43] Shrybman, S. 1989.

pesticides and other chemicals in the food we eat and the products we use.[44]

2.8 Nutrition

Because of a woman's capacity as a childbearer, as well as her changing hormonal make-up and normal fluctuation in body size over her lifetime, her nutritional requirements are different from those of men. For example, adequate calcium intake is critical from very early years to insure that a woman does not put herself at risk for osteoporosis in her later years.[45] As Health and Welfare's *National Guidelines for Nutrition in Pregnancy* indicate, "maternal nutrition is one of the important environmental variables influencing the progression and outcome of pregnancy. Poorly nourished women jeopardize their own health and are at risk for delivery of low birthweight babies...[who have] a greater potential for perinatal mortality and physical and mental handicaps".[46]

Many adolescent and adult Canadian women consume inadequate amounts of nutrients essential to their health to the point where, on average, adult women have the highest rates of under-nutrition in North American society. The nutrition literature indicates a gap in the adequacy of dietary intakes between men and women, even between individuals sharing the same meals.[47]

The ironic twist is that women shoulder most of the responsibility for ensuring that family members are properly fed. Part of the reason for their inadequate diets, which include a lack of sufficient intake of calcium, zinc, manganese, copper, magnesium and iron, is that women continue to be preoccupied with weight control.[48] Louise Lambert-Lagacé has noted that two out of three women in Canada are continually trying to lose weight and are chronic semi-fasters[49], in spite of the fact that about 85% of Canadian women fall within or below Health and Welfare Canada's healthy weight range.[50] Ninety to 95% of people with anorexia nervosa and bulimia are women. A culture of thinness propagated by several powerful industries (fashion, cosmetics, media and entertainment, tobacco) is only one reason for women's inadequate nutrient consumption. Women's pre-occupation with weight also has its origins in their inferior role in society and this culture's

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[44] Environmental activists have suggested that the chemicals used on food be as prominently displayed as the price.

[45] Osteoporosis, a condition of porous bones which contributes to an overall structural weakening of the bones, affects over 800,000 Canadian women over 50 [Osteoporosis Information Centre, Ostop Ottawa]. Calcium intake throughout a woman's lifetime is only one preventive measure which decreases women's risk of developing osteoporosis. For more on osteoporosis, see "Health Issues for Senior Women" below.

[46] Federal-Provincial Sub-committee on Nutrition, *Nutrition in Pregnancy: National Guidelines*. Ottawa: Health and Welfare Canada. May 1986.

[47] Lambert-Lagacé, Louise. "Nutritional health of women" in *Rapport*, Vol.4, No. 4, 1989, p.1.

[48] Canada's Health Promotion Survey (*Selected Data*, Figure 15).

[49] Louise Lambert-Lagacé, 1989, p.1.

[50] *The Active Health Report - Perspectives on Canada's Health Promotion Survey, 1985*. Ottawa: Health and Welfare Canada, 1987.

emphasis on women's physical appearance as a measure of worth and success. Edwards also points out that "food nourishes empty lives and fears of failure"[51] to which Lambert-Lagacé adds that little research has been done on the effect of isolation (which affects three times as many women as men) on nutrient intake.

Poverty, socialization to attend first to the nutritional needs of other family members, living alone and busy schedules contribute to women's poor nutritional intake. Inadequate nutrient intake puts women at risk for a variety of chronic and degenerative health conditions, making this issue an important health promotion and disease prevention issue for Canada. In order to enhance the nutrition status of women, women's health policy should include the consideration of psychological factors which orient women away from adequate nutrition, cost factors, and educational programs to help young women develop healthy attitudes about their bodies and their weight along with an awareness of the importance of sound nutrition habits beginning in their younger years.

2.9 Fitness ("Active Living")

Fitness Canada has lobbied for a shift to use of the term "active living" as opposed to fitness or exercise. The concept of active living attempts to dispel the myth that fitness is limited to a particular time, facility or activity. This is particularly important for women because traditional measures of "fitness" often focused on structured activities. Women not in the formal workforce are often overlooked for their participation (or lack of) in such activities.

Canada's Health Promotion Survey[52] revealed that 29% of women never or seldom (less than once a week) engage in exercise. Sex differences in rate of activity vary across the country, but women consistently are less active than men. In Canada's Fitness Survey (1981), more women than men aged 20 to 29 performed at the recommended cardiovascular fitness level. However, with increasing age, the gap widens significantly. By age 40 to 49, 49% of men compared to 35% of women are at the recommended level.[53]

With the double workload which many women carry, it is perhaps not surprising that more women than men cannot find the time to work regular exercise into their daily routines. Although the workplace has been suggested as an ideal setting for fitness programs, it is questionable how advantageous this would be to women. A significant percentage of women are in the service sector, which tends not to lend itself well to organizing group fitness activities. Also, a significant percentage of women work part-time. It has been argued that organization of more programs at a community level may have a greater impact on women.

Physical activity, fitness, or the concept of active living can be important for women on many levels. It increases self esteem and can influence diet, stress and cardiovascular health. Employers who set up physical fitness programs for their employees do so because they have

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[51] Edwards, Peggy, 1989, p.6.

[52] Health and Welfare Canada. *Canada's Health Promotion Survey, Technical Report.* 1988.

[53] Statistics Canada. *Women in Canada: A Statistical Report,* 1985.

observed that fit and healthy employees tend to use fewer workplace health services and less prescription and non-prescription drugs.

In spite of their overall lower rate of active participation, women's rate of activity has improved in the past decade.[54] A broad range of strategies is required to ensure that women's participation in active living continues to increase. Strategies for active living geared to women working both in and outside the home must be researched and addressed.

[54] Canadian Fitness and Lifestyle Research Institute. *Campbell's Survey on Well-being in Canada*, 1988.

B. Special Population Groups

Women, who comprise 51% of the total population, are not a homogeneous group. Consequently, they also comprise a substantial proportion of all minority populations. Being a woman *and* a member of a minority can compound the extent to which they are disadvantaged.

2.10 Health Issues for Women with Disabilities

As a minority, and amongst the poorest of all Canadians[55], women with disabilities encounter significant barriers to obtaining quality health services. Organizations such as the DisAbled Women's Network (DAWN Canada)[56] and the Coalition of Provincial Organizations of the Handicapped[57] have been instrumental in raising public awareness about issues affecting women with disabilities. These issues may not always be a priority for organizations working for disabled people. Health and Welfare's Key Informant Survey also revealed that health issues for women with disabilities were an important women's health issue in Canada.

One of the most notable health issues for women with disabilities is the lack of access to appropriate services. This varies according to the particular disability, but most women's health and social services are not very accessible to women with disabilities.[58] For example, women who use wheelchairs require ramps, wide, automated doors, and grab bars in washrooms. Women who are deaf or hearing-impaired may require sign language interpretation, Telecommunications Devices for the Deaf or infrared systems. Blind and visually-impaired women need information on tape, large print or Braille. Women with environmental illnesses require smoke-free environments, and many women with disabilities have specific requirements for nutrition or rest breaks.

Accessibility also applies to attitude. Society tends to stereotype people with disabilities, using such negatively charged language as "victims of", "afflicted with" or "confined to a wheelchair".[59] Lack of sensitivity from caregivers, including health care professionals, has been

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[55] Ross and Shillington, p.28, 1989.

[56] A national, voluntary organization controlled by and comprised of women with disabilities, DAWN Canada began in Ottawa in 1985, and now has local chapters across Canada. Acting as a voice for women with disabilities, DAWN's goals include "making women's services and the women's movement accessible to all disabled women, acting as a bridge between the women's movement and the disabled consumer movement, providing role models for disabled girls, addressing issues of affirmative action, poverty, violence, parenting, sexuality, and health". [from DAWN Toronto brochure]

[57] Taking its lead from DAWN, COPOH produced a discussion paper on issues for women with disabilities in 1987, and more recently produced a pamphlet focusing on reproductive rights, violence and health issues for women with disabilities. COPOH is "a voluntary umbrella organization which coordinates the views of provincial citizenship self-help groups at the national level to improve the status of disabled person's in Canada". [COPOH publicity brochure]

[58] DAWN Toronto. "Are You Accessible?", a pamphlet written and produced by DAWN, 1989.

[59] It has been noted (Sawin,K., 1986, p.238) that people who use wheelchairs are not necessarily confined to them and in fact, "many view their wheelchairs as liberating because they provide independent mobility".

mentioned by many women with disabilities[60] particularly with reference to such issues as sexuality and birth control, clearly affecting the emotional health of women with disabilities. Society has assumed that women with disabilities are not sexual[61] and, therefore, do not require information about sex, sexuality or birth control. This is reflected in the lack of accessibility to birth control clinics, the absence of appropriate examining tables for women with certain disabilities and the extent to which women with disabilities have not been consulted about sterilization procedures.[62]

These physical and attitudinal barriers, along with low self-image, create a strain on the mental health of women with disabilities. Low self-image was identified as a key concern of women attending the inaugural meeting of DAWN Canada. Few girls with disabilities grow up with positive role models. They live in a culture which emphasizes physical attractiveness in women. As adults, they have fewer job opportunities [63] and higher rates of poverty than men with disabilities.

Evidence is emerging that women with disabilities experience more violence against them than women without disabilities in their lifetime, often from those who are in charge of their care. In a study conducted by DAWN Canada in 1988, 40% of women who responded had been raped, abused or assaulted, 64% had been verbally abused and women with multiple disabilities are multiply abused.[64] Few services for assaulted women are accessible to women with disabilities and, as victims of violence, some say they experience worse treatment than able-bodied women from the medical profession. As one respondent to the DAWN study put it:

> "Symptoms that indicate sexual abuse and incest in able-bodied women are overlooked by many physicians. Such symptoms are even more likely to be overlooked in women who are not seen as women but as a "case" of multiple sclerosis or cerebral palsy."[65]

Some advocates for people with disabilities have argued that the emergence of prenatal diagnostic techniques such as ultrasound, amniocentesis, and chorionic villi sampling is raising complex ethical questions about the value which we place on people with disabilities in our society.[66] Since couples can now "select out" fetuses which may have a handicap, such as Down's Syndrome or spina bifida, some question whether this growing practice may ultimately lead to increased discrimination against those with disabilities and less support for them.

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[60] Ridington, 1989; McDonnell, ed. *The Healthsharing Book*, "Women with disabilities" (Pat Danforth), 1985.

[61] Ridington,Jillian. *Who Do We Think We Are? Self-Image and Women with Disabilities*. Position Paper 1 prepared for DAWN Canada, February 1989.

[62] Ridington, ibid.

[63] Gower, D., 1988.

[64] Ridington, March 1989.

[65] Ridington, February, 1989.

[66] Tait, J. 1986.

As a result of the work done by DAWN and other advocacy groups for people with disabilities, increasing numbers of health and social service facilities are incorporating renovation costs to improve accessibility into their budgets. A Status of Disabled Persons Secretariat has been set up within the Department of the Secretary of State with similar provincial offices across the country.

Education is needed to bring society in general and the health care profession in particular to a level of understanding about the true needs of women with disabilities. The creation of health information materials and facilities must involve women with disabilities in the planning stages in order to ensure that their needs are met.

2.11 Health Issues for Immigrant Women and Women of Colour

In 1986, one in four Canadians reported their ethnic origin as being neither English nor French.[67] Immigrants who have most recently come to Canada tend to experience the most difficulties in receiving the quality of health care enjoyed by other Canadians. As a doubly disadvantaged group, immigrant women experience considerable problems. Barriers faced by immigrant women and women of colour include lack of information about services, insensitivity on the part of health care personnel because of cultural practices and problems associated with services designed for a mainstream population. An immigrant woman's inability to communicate her problem effectively to her health care provider can result in inappropriate treatment.[68] In comparison with immigrant men, women face the additional burden of having less access to language and skills training[69].

The National Organization of Immigrant and Visible Minority Women of Canada, an umbrella non-governmental organization representing over 500 immigrant and visible minority women's groups in Canada, has presented substantial briefs to the federal government outlining its concerns. It has recommended that relevant activities be initiated federally, provincially and territorially (as appropriate) to address the following specific concerns related to health care:

- availability of multilingual information on health services and programs
- preparation and distribution of culturally-sensitive health-related materials
- research into the health needs and risks of immigrant women and women of colour
- programs recognizing and reflecting the needs of immigrant women and women of

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[67] White, P. (1989), p.13.

[68] Bodnar, in McDonnell,ed. *The Healthsharing Book*, notes that "in hospitals, women have been misdiagnosed because they can't communicate with doctors and given surgery when none is needed. Anxiety attacks have been treated by injections of tranquillizers in emergency rooms, with no investigation of cause or recommendation for follow-up treatment" (p.145). Lee has further noted that the most frequently prescribed drugs for immigrant women are major tranquillizers, followed by anti-depressants and anti-psychotics.

[69] Christina Lee. Address to National Symposium on Changing Patterns of Health and Disease in Canadian Women, 1988.

colour, specifically in mental health, family violence, occupational health and health of the elderly
- mechanisms for relevant community input and feedback
- funding for training of health professionals for both mainstream and ethno-specific services
- training of interpreters
- employment equity in health services

In 1987, the Senior Adviser Status of Women for Health and Welfare Canada prepared a report for the Federal/ Provincial/ Territorial Advisory Committee on Community Health outlining the current status of activities and initiatives of the provinces and territories regarding the health concerns of immigrant women and women of colour.[70] A considerable degree of activity is taking place at all levels. For example, efforts to address the need for multilingual information on health services was reported by 8 provinces and the distribution of appropriate materials was reported in 5. Health-related programs for immigrant women and women of colour were reported by most provinces with some being carried out not by departments of health but such departments as urban affairs and education. While research is going on in most provinces, the services of interpreters are provided primarily through the goodwill of non-governmental organizations and individuals. Eight provinces reported employment equity programs for women and for Natives but, with the exception of Ontario, programs have not specifically focused on or targeted employment of women of colour in the health care sector.

At the federal level, the Canadian Multiculturalism Act received Royal Assent in July of 1988 and the Secretary of State announced $192 million for new directions in the multiculturalism policy of Canada. The Federal/ Provincial/ Territorial Advisory Committee on Mental Health is being asked to consider the findings of the Task Force on Mental Health Issues Affecting Immigrants and Refugees, which had a special focus on the health of women.[71] According to the report: " The higher incidence and intensity of risk factors create special mental health needs for immigrant and refugee women" (p.78). In response to the recommendations of the report, Health and Welfare and the Secretary of State have agreed to jointly explore the feasibility of developing centres of excellence for cross-cultural training and research on issues affecting migrant mental health.

The Southam report on literacy and health noted that the health care problems faced by Canada's five million illiterate people are often the same as those faced by immigrants who cannot read English or French. These problems include: an inability to read directions on medication; mistakes in food preparation because of an inability to read food packaging; an inability to read health information brochures; an inability to read written instructions from nurses and doctors; and an inability to read signs in the workplace resulting in more workplace accidents. In light of the significant role which women play as disseminators of health information to family members, their ability to read takes on additional importance.

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[70] Paltiel, Freda. *Provincial Responses: Activities and Initiatives to Address the Health Concerns of Immigrant and Visible Minority Women.* Ottawa: Health and Welfare Canada. 1987.

[71] Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. *After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada.* Ottawa:1988.

2.12 Health Issues for Native Women

Three per cent of the Canadian population (or just over 3/4 of a million people) are aboriginal (Indian, Inuit or Métis)[72], 50% being women. The average life expectancy for Native women is 7.4 years less than that for non-Native Canadian women.[73] Traditionally, in most of the provinces, aboriginal peoples lived on reserves. However, many have now moved to smaller communities or urban centres. In the territories, aboriginal people live predominantly in small communities and a few major centres. In the Northwest Territories in particular, many of these communities are very isolated and can be accessed only by air transportation. In discussing the health needs of Native women, a distinction must be made between issues relevant for those who live on reserves and in remote areas versus issues for those who live in larger urban centres.

There are many health issues for the Native women of Canada and they stem from a variety of complex factors. Literacy rates for Canada's Native population are far below the Canadian average, a factor which has an unquestionable impact on their health. Isolation, lack of services and transportation difficulties, particularly in the territories, all adversely affect Native women's health. In remote areas, the lack of job and educational opportunities are further barriers to Native women fulfilling their potential. In addition, Goodwill writes: "...the loss of faith in their own institutions and values has resulted in a demoralization and sense of powerlessness in Indian communities throughout this country".[74]

The incidence of many diseases, such as respiratory disease, eye and ear infections, dental problems, hypertension and gastro-intestinal problems, which are often linked to the socio-economic realities of the lives of many aboriginal peoples, are much higher among Native women. The incidence of diabetes is particularly high in the Native population. Rates for cancer of the cervix, sexually transmitted diseases and cirrhosis of the liver are higher than the Canadian population. Many deaths are related to violence, suicide, injuries and alcohol abuse. Mortality rates on Indian reserves for violent deaths are three to four times higher than Canadian rates in general.[75] A study conducted by the Ontario Native Women's Association whose report was released in 1990 revealed that eight out of ten Indian and Métis women have suffered some form of abuse, usually at the hands of their husbands.[76]

There are some positive changes occurring. In 1979, the federal government adopted a new Indian Health Policy resulting in the gradual transference of health services to the Indian people. The Northwest Territories report that women make up close to 50% of representation on the Regional Health Boards which were set up to coincide with the transfer of health services from the

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[72] *Canadian Social Trends*, Summer, 1989.

[73] *Selected Data*, Figure 7.

[74] Goodwill, Jean, 1989, p.118.

[75] Mao et al, 1986, p.267.

[76] *Toronto Star*, January 19, 1990.

federal to territorial level. The Boards provide for participation of local people in the decision-making process regarding the delivery of health services in their region. Native women in the Northwest Territories have been very active in this process, particularly related to such issues as family violence, midwifery, and child care.

The Yukon Indian Women's Program - "Dene Nets - Edet - An" (meaning "People Awakening")- have an innovative program aimed at creating community support groups interested in pursuing personal or community development. Community training is based on the self-care model, balancing the physical, mental, emotional and spiritual well-being of participants. Community issues pursued include family violence, alcohol and drug abuse, Mission School Syndrome, and adult children of alcoholics.

In March of 1990, the Yukon Women's Directorate released a report on Yukon Women which clearly delineated means of achieving an improved health status for Native women. These included:

* assisting community groups to provide safety and support to abused women and children;
* improving the quality, affordability and accessibility of child care services throughout the Yukon;
* improving family planning, STD and family life counselling and information to teenagers;
* encouraging the participation of women in addressing issues pertaining to new reproductive technologies.

There is a need for more aboriginal people to be trained in the health professions. More Native women are entering the nursing profession, partly as a result of the creation of the Indian and Inuit Health Careers Program launched by the Medical Services Branch of Health and Welfare in 1984. The Community Health Representative Program prepares Native people at the college level for a role as front-line health workers with a particular emphasis on health promotion activities.

Infant morbidity rates are not good amongst Native children; at the same time, it is now rare for Native women to die in childbirth. The overall gain for some Native women in this improvement in mortality rates, however, has been at the expense of having to be flown out of their communities to larger centres for confinement.[77] The overall emotional and social consequences of this type of displacement, as well as concern about the identity of children born outside their province or territory, need to be studied.[78] Breast-feeding has also made an impressive comeback among Native mothers. In comparative studies, it was found that 49% of Native mothers were breast-feeding in 1983 compared to 26% in 1962.

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[77] Most women in the Northwest Territories who experience normal pregnancy and birth deliver their babies in hospital facilities within the Territories. In the Keewatin region, because there is no regional hospital, women are flown out to Churchill or Winnipeg boarding homes at 36-37 weeks gestation to await the beginning of their labour.

[78] A research study at the University of Manitoba Medical College's Department of Social and Preventive Medicine is looking at the impact of evacuation for childbirth on Inuit women in the Northwest Territories, Keewatin area. Another study, funded by the National Health Research and Development Program and conducted by the Pauktuutit-Inuit Women's Association, is documenting the traditional Inuit practices related to pregnancy and childbirth.

As Canada's aboriginal peoples move closer to a state of self-governance, some speak of the importance of returning to the more traditional healing practices of their ancestors. Native women repeatedly emphasize the importance of adopting a holistic approach to deal with women's health care needs. The appropriate social and economic resources will make it possible for this to happen along with the development of an underlying foundation of culturally appropriate health information materials produced by and for aboriginal peoples.

2.13 Health Issues for Adolescent Girls

Adolescence is a transition period between childhood and adulthood. It is a critical period of rapid physical growth, physiologic change, sexual development, identity formation, intellectual maturity and change in body image.

During adolescence, girls tend to evaluate themselves in relation to others, leading to worry about self-image. They often experience guilt about their sexuality and can be ill-equipped to make difficult decisions about sexuality and birth control at a time when they are physically capable of becoming pregnant. Many adolescent beliefs and attitudes related to perceived benefits of risk-taking behaviour, peer pressure and their own sense of vulnerability contribute to the overall health of adolescent girls.

At the Colloquium on Adolescent Girls Health, sponsored by Health and Welfare Canada in 1984, the following health issues were identified for this group:

i) Stress

In discussing mental health, Dr. Mary Yack explained that adolescent girls tend to suffer from a poorer self-image, greater self-consciousness, lower self-esteem and a higher level of instability than adolescent boys. They also tend to be less satisfied with their sex role, less future oriented with respect to education and career, and more dissatisfied with their physical appearance.

Lower self-esteem in adolescent girls was corroborated by the findings of the *Canada Health Attitudes and Behaviours Survey* (King et al, 1985) and the *Canada Youth Foundation Survey* (Posterski and Bibby, 1987).

ii) Reproductive Health Problems

Canadian youth are sexually active at a very young age, and consequently are at risk of contracting sexually transmitted diseases. According to the *Canadian Youth Foundation Survey*, approximately 45% of 15 to 19 year olds had sexual intercourse. In the *Canada Youth and AIDS Study* (King et al, 1988), 21% of adolescent girls in grade 9 and 46% of those in grade 11 had had sexual intercourse at least once. This was also true of 81% of female drop-outs.

The largest increase in reports of chlamydia between 1985 and 1986 was in the 15 to 19 year old age group, with a male to female ratio of 1 to 10 (Acres, 1987). Although there has been an overall decline in the rates of reported gonorrhoea in the general population, the rate for 15 to 19 year old females increased in 1984 and 1985 , and in 1986 was almost twice that of males in the same age group. Sex-specific data on the prevalence of HIV infection among adolescents are

not available although 20% of the reported adult cases of AIDS are in the 20 to 29 years group. Given the long latency period, many may have been infected in their adolescence.

Pregnancy is an obvious consequence of adolescent sexual activity. Although the fertility rate for 15 to 19 year olds is declining, in some parts of the country, adolescent births comprise 15 to 20% of all live births.[79] The decline is less marked among younger than older teens. The therapeutic abortion rates for 18 and 19 year olds increased slightly between 1977 and 1987.

A range of initiatives has been undertaken across the country to address the issues of adolescent pregnancy and parenting, sexuality and family planning. These include the Committee on Unplanned Pregnancy in Manitoba, the "Nobody's Perfect" parenting program, a network of reproductive health clinics in New Brunswick, confidential telephone information lines, theatre groups and open-line radio programs aimed at teens.

iii) Use of Alcohol and Drugs

Ten per cent of girls in grade 9, 17% in grade 11 and 35% of female drop-outs reported weekly alcohol consumption (King et al, 1985). In this study, males and females were equally likely to use cannabis.

Adolescent girls now smoke as much as adolescent boys.[80] In 1986, 17% of adolescent girls between 15 and 19 years smoked daily.[81] Eighty per cent of women who currently smoke started in their adolescence. Women also have a particularly difficult time quitting, and with lung cancer rates on the increase for women, this smoking rate in adolescence is a concern.

The Health Promotion Directorate of Health and Welfare has developed several projects related to alcohol, cigarette and drug use, including the "Generation of Non-Smokers" program, "Stay Real: Cannabis Information Campaign" and "Dialogue on Drinking".

iv) Nutritional Problems and Poor Fitness Levels

Obesity related to poor eating habits and lack of exercise is still a common problem for adolescent girls. A 1986 study of Ottawa high school students found that about half the normal weight girls were dieting needlessly because they thought they were overweight.[82] Research has shown that activity and fitness levels begin to decline in early adolescence, and adolescent girls score poorly on cardiovascular fitness tests.[83]

There is need for a national data base to document specific health needs of adolescent girls so that data is not extrapolated from surveys on children or adults. The advertising industry and media need information in order to promote acceptance of variations in body size, the concept of

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[79] Myers, 1985.

[80] Postrski and Bibby, 1987.

[81] Health and Welfare Canada, 1986.

[82] Feldman,W., McGrath,P. 1988.

[83] Fitness & Amateur Sport, 1984; King et al, 1985.

personal responsibility for behaviour, positive role models for adolescents and the notion of health promotion. The particular health needs of adolescent girls need to be incorporated into the programming of health clinics and women's health centres and this age group needs to be involved in the planning of health promotion endeavours nationwide.

2.14 Health Issues for Senior Women

According to Canada's Chief Statistician, "...the proportion of the population 65 years and older is likely to double within the next 50 years, and the proportion of the very old (85 and older) will likely grow twice as fast". Seniors, who now comprise just over one-tenth of the population, are expected to form one-quarter of the population in 2031. Some have come to identify the issue of aging as a women's issue since older women make up the majority of Canada's senior population.[84]

Canadian women's disability-free life expectancy is only 3.6 years longer than that of men compared to a life expectancy at birth of 7.5 years longer than men. Women who survive to age 65 can expect to spend almost half (47%) of their remaining years with some form of disability.

The relationship between poverty and poor health is evident. Nearly three out of ten individuals with low incomes in Canada in 1985 were senior women. Since 1980, the rate of low-income status for all unattached seniors (80% of whom are women) has dropped steadily from 62% to 44% in 1987. Despite social security measures which have succeeded in reducing the rate of low income among senior unattached individuals, unattached women are much more likely to have low incomes in their old age. Seventy-three per cent of seniors with low incomes are women.

At a conference on women in an aging society in Halifax in 1988[85], a bias equating old age with disease, worthlessness and incompetence was described as influencing the diagnosis and treatment of senior women. Conference participants noted that such bias is often the determining factor used to inappropriately eliminate senior women from health promotion and screening programs (such as for breast and cervical cancer where a high prevalence exists in this age group). The conference called attention to the serious lack of understanding of the true dynamics of holistic geriatric care and the need for gender-sensitive , specialized, multi-disciplinary assessment and treatment services with continuity of care in the health care system.

Less than 10% of Canadians over 65 are cared for in institutions, the greater proportion being over 75 years. It should be noted, however, that in comparison with Europe, Canada has a relatively high rate of institutionalization of seniors and a low rate of community services and facilities. Services which allow seniors to stay at home and function at their highest level - including intermediate resources, specialized or adapted housing, home care services, rehabilitation services, respite care, day hospitals, day centres, short-stay geriatric and psychogeriatric services - are unequally distributed across Canada. The National Advisory Council on Aging emphasizes the importance of less costly and more flexible transportation schemes, community wellness clinics,

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[84] McDaniel, Susan, 1986.

[85] *Women in an Aging Society: Report of the Proceedings*. National workshop, Halifax, Nova Scotia, October 20, 1988. Ministry of Supply and Services Canada, 1989.

crisis telephones lines and centres and affordable assistive devices. There is a growing recognition amongst those delivering long-term care that appropriate, quality institutionalized care places an emphasis on quality of life, with programs based on social, rehabilitative and health maintenance models.

Depression and senile dementias have been described as the most common functional mental disorders of later adulthood. Alzheimer's disease, affecting twice as many women as men, is more common at advanced ages, affecting 5 to 10% of people over the age of 65 and 10 to 20% of people over 75. Since women are more likely to outlive their spouse and, therefore, live alone, female Alzheimer's victims are more likely to be institutionalized in the early stages of the disease. The Round Table on Aging[86] called attention to the relationship between depression and social isolation and lack of social identity frequently found among senior women.

Osteoporosis, a condition in which bones become porous and fracture easily, is primarily a female disease affecting one in four women over the age of 60. A fracture of the hip can result in disability and complications leading to death, with 15% of women dying shortly after a hip fracture and 30% within a year. It has been noted [87] that the condition of osteoporosis is highly preventable, since smoking, alcohol consumption, calcium and Vitamin D-deficient diets and lack of weight-bearing exercise contribute to the disease.

Malnutrition is widespread among seniors irrespective of socioeconomic level, placing this age group at risk for infection and other debilitating diseases. Many seniors do not eat well because of the cost of nutritious food, lack of mobility to shop, lack of information on the important relationship between diet and health, a lack of incentive to eat alone and a lack of physical capability or facilities to cook.

Loss of function is a frequent reality and concern of seniors. This includes visual and hearing impairment, mobility constraints and urinary incontinence. The problem of urinary incontinence, affecting 10 to 15% of all seniors, is said to be twice as high in women as in men[88] with an incidence as high as 50% amongst older women in hospitals. It is one of the three leading causes of admissions to nursing homes and accounts for 25% of nursing time in nursing homes. Treatment and prevention methods are available but require further research.

Inappropriate and excessive use and abuse of prescribed and over-the-counter drugs and, for some, the inclination to combine this with alcohol, constitute major health risks for senior women. The Canadian Medical Association recognizes seniors as a special risk group in its new guidebook to drugs and lists special precautions for this group under different drug classifications.

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[86] *Proceedings of the Round Table on Women and Aging, Ottawa, January 24-26, 1988.* Health and Welfare Canada (Senior's Secretariat) and Status of Women Canada.

[87] Cobb, 1989.

[88] Porcino, p.290, 1983.

Examples of specific problems include the following:

* Older women use more than twice as many prescription drugs and more non-prescription drugs than older men; senior women who live alone use more drugs than other women.

* Physicians are twice as likely to prescribe tranquillizers for women as they do for men.

* "Polypharmacy" involves not only the number of drugs being prescribed, but the number of different physicians involved in prescribing, due to multiple referrals for different ailments.

A Seniors Independence Program launched in 1988 is funding projects across Canada aimed at improving the quality of life and independence of seniors, and a research fund has been established which will focus on diseases affecting seniors (particularly Alzheimer's disease and osteoporosis). In 1989, British Columbia launched a Seniors' Drug Action Program which funds a number of projects aimed at reducing medication misuse and promoting rational prescribing of medication.

Appropriate health promotion efforts will assist senior women to maintain their health and reduce their vulnerability to illness. Health planners for the future will do well to focus on such health promotion activities as safety measures, medication management, smoking avoidance, good nutrition, exercise, stress management and education for seniors regarding the normal aging process.

3. KEY CHALLENGES FOR WOMEN'S HEALTH IN CANADA TODAY

The more we understand of the economic and social realities of the lives of women in Canada, the better we will understand why women's health requires a separate focus and why there is need for changes. In addition, we must examine the historical factors which have contributed to the study of women's health in Canada today to best appreciate where change is most needed. [For an historical perspective on women's health in Canada, see **Appendix B**] The following section will look at some indicators of the main social and economic factors which influence women's health, as well as women's access and relationship to the health care system both as consumers and providers of care. Some of the factors presented are strengths while others are barriers to improving women's health status. Together, they comprise the unique challenges facing those seeking change in women's health in Canada.

3.1 THE SOCIAL AND ECONOMIC REALITIES OF WOMEN'S LIVES

3.1.1 Women are poorer than men.

The relationship between poverty and poor health now comprises a substantial body of literature in the health care field.[89] Ross and Shillington (1989) have noted that while lack of income cannot be proven to be the *cause* of ill health, there are certainly strong associations between the two.[90] Adequate health is not only dependent on universal access to health care and social supports but on factors, such as nutrition and good housing, which are directly affected by income.

In 1990, women, *overall*, still earn only $.66 to every dollar earned by men[91]. There are many "hidden factors" which contribute to this gap. One is women's continued economic dependence on men, resulting in large part from socially prescribed notions about who is the most

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[89] *Achieving Health for All* (1986); Calamai (1988); Gee & Kimball (1987); Harding (1987); Lowe (1989); Paltiel (1987); Public Health Service Task Force on Women's Health Issues (1985); Rachlis & Kushner (1989); Ross & Shillington (1989); Wilkins & Adams (1983).

[90] Ross & Shillington, p.1.

[91] Statistics Canada, Catalogue No.13-217, 1987.

appropriate caregiver in the home. Another is the low social status accorded to most female occupations. (Consider, for example, the low salaries paid to child care workers.[92]) Women also comprise more than 3/4 of the part-time labour force[93] (a choice which many make because it allows them more time to be involved with their families) with the ensuing economic disadvantages, such as lower benefits, less accumulated experience and seniority, which that entails.

In 1987, 42% of women had low incomes[94] compared to 32% of men.[95] In 1986, 56% of families headed by women with dependent children under 18 and 52% of unattached elderly women had incomes below Statistics Canada's low income cut-offs.[96] Single-parent families headed by women increased from approximately 1/4 to 1/3 of all poor families in Canada between 1973 and 1986.[97]

3.1.2 Women experience discrimination on the basis of their sex.

In a society where discrimination on the basis of sex still exists, women's use of and role in the health care system must be considered in that light. The *United Nations' Convention on the Elimination of All Forms of Discrimination Against Women*, ratified by Canada in 1981, summarizes the problems which still existed in 1988:

> "Since women still assume most family responsibilities, their flexibility to assume responsibilities outside the home remains limited. This is accentuated by the low level of child care facilities...the gap between the earnings of men and women remains high. Women are still concentrated in lower paid occupations and access to jobs that provide higher wages and better advancement possibilities remains difficult. Lone female parents and lone elderly women are particularly vulnerable to economic difficulties. Since women are under-represented in public life, they are not always in a position to influence the decisions which may affect their lives... attitudes and perceptions still remain which stereotype women in traditional roles and retard changes necessary to their full participation." [98]

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[92] In Manitoba, for example, the average salary for a trained child care worker is $16,000.

[93] Women's Bureau, Labour Canada, 1986.

[94] Defined by Statistics Canada as under $13,400.

[95] Statistics Canada, Catalogue No. 13-207, 1987.

[96] Poverty File. Canadian National Council of Welfare, 1988.

[97] Ross & Shillington, p.23, p.41.

[98] *Convention on the Elimination of All Forms of Discrimination Against Women, Second Report of Canada*. January 1988. Minister of Supply and Services Canada 1988. Cat. No. S2-104/2.

A recognition of the existence of discrimination against women and the need to protect women against it was evidenced by the inclusion of equality guarantees in the Canadian Charter of Rights and Freedoms in 1982.(Sections 15 and 28[99]) We are only beginning to see the full implications of these historically important documents for women's health. Stronger consideration must be given to the degree to which discrimination per se negatively affects women's health, and the potential relationship between the scarcity of women in senior health positions and systemic discrimination. In general, we need to better understand the effects on one's mental health of living with discrimination.

Special provisions need to be made in health care policy to counteract the negative consequences of living with discrimination. This applies doubly for those who are discriminated against on the basis of sex as well as for their membership in a minority group.

3.1.3 Women are more likely than men to experience violence.

In Canada, one out of every 8 to 10 women is battered by her partner or spouse[100], and one in every four women will be sexually assaulted. The full impact of these experiences on women's mental and physical health is yet to emerge, but is substantial.

In a landmark study on wife abuse in this country, author Linda MacLeod noted that "To be a battered woman is, by definition, to be isolated, to have few friends, often limited access to money and to be trapped in a cocoon of secrecy." [101] MacLeod also noted that for every woman accepted at a transition house in Canada, one is turned away and that the rate is even greater in larger urban centres like Toronto.[102] Rural and isolated women experience additional difficulties due to attitudes of disbelief and lack of services.[103]

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[99] Section 15: "Every individual is equal before and under the law and has the right to the equal protection and the equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability". (Subsection 1)

Section 28: "Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons".

[100] MacLeod, Linda. *Battered But Not Beaten... Preventing Wife-Battering in Canada.*

[101] MacLeod, p.22.

[102] ibid, p.7.

[103] For more discussion on the impact of violence on women's health, see the discussion above on page 7.

3.1.4 Women live longer than men.

Women's greater longevity would appear to be an indication of their superior health status. However, the opposite is true. Although women outlive men by an average of 7 years in Canada, they experience more chronic illness and disability than men because they live longer. In brief, women suffer higher morbidity rates and men higher rates of premature mortality.[104] Medical research tends to give priority to the life-threatening diseases, such as heart attacks, more commonly experienced by men, as opposed to the degenerative and debilitating diseases, such as arthritis, which affect women to a greater extent than men.

In Canada, being older and female means having a higher chance of being poor and developing the illnesses which ensue from living in poverty.[105] When an older woman is Native or disabled, the possibility of living in poverty is even greater.[106]

3.1.5 Many women have a double workload: one in the home and one in the paid workforce.

The female proportion of the paid labour force has risen from 34% in 1970 to 44% in 1988. Indeed, the last two decades have seen a dramatic rise in participation rates and the presence of women in the paid labour force. The largest increases in participation rates were recorded for married women (42% in 1975 to 59% in 1988) and women with children under the age of 3 of whom 58% are now in the paid labour force.[107] This represents a sizable number of women with a double workload.

However, women still assume the bulk of home and family responsibilities, regardless of whether or not they are in the paid labour force.[108] The subsequent effects on both the physical and mental health of women is an important health issue. An historically significant event occurred when the issue of work and family responsibility integration appeared on the agenda of the First Minister's conference in November of 1989.

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[104] It is noteworthy that the reverse is true for boys and girls. Verbrugge and Wingard (1987) have noted that "boys uniformly have poorer health and [require] more health services than girls". p.124

[105] Gee & Kimball, 1987.

[106] Ross & Shillington, p.28.

[107] Historical Labour Force Statistics. Statistics Canada, 1988.

[108] The Statistics Canada *General Social Survey* of November 1986 revealed that women, whether employed in or outside the home, still assume more responsibility for all household tasks. For example, in the area of meal preparation and clean-up, 77% of women prepare meals on any given day in comparison with only 29% of men. In addition, women tend to spend more time at any given household task than do men. (*Canadian Social Trends*, Spring 1990)

3.1.6 Women provide most unpaid, informal health care services and play a key role in influencing the health care behaviours of others[109].

Women's unpaid work includes childrearing, housework, and the care of elderly, sick, disabled and chronically ill family members. Heller (1986) has elaborated on some of the more hidden aspects of this work: "[Women] stay at home more often when someone is ill, take children to the doctor more frequently, repeatedly get up at night with sick children, are more aware of the psychological aspects of children's life at school and with friends...look after nutrition, offer psychological support and monitor psychological well-being, assume responsibility for reminding other family members about medical and dental check-ups and making appointments...provide home nursing and health and sex education".[110]

The health care component of this unpaid work has often been referred to as "the informal health care system"[111]. It has been viewed as "the least well-documented area of women's health work"[112], and undoubtedly represents the most significant amount of health care labour carried out by women. Aronson (1986) estimates that 90% of health care is this informal care and Buck (National Symposium) states that three-quarters of all illnesses are being looked after outside the formal health care system. No accurate data exist.

Callwood (1987) explains that "the primary health care women provide on the front lines of their homes is an invisible phenomenon. Its dollar value is not readily available for statistical analysis because the women are unpaid: their immeasurable contribution to the quality of life in Canada, and even to life itself, is largely unacknowledged because it is taken for granted. Home care for the sick, the old, the young, the disabled is what women do".[113] This health care role which women perform has been referred to as the role of "health guardians in the home", a term which was used in a 1986 study of the Canadian Advisory Council on the Status of Women, *Health and Home: Women as Health Guardians* (Heller, 1986).

While the care of family members has its rewards for many women, social and economic factors can contribute to a sense of exhaustion and isolation which women may have difficulty expressing. As Paltiel has noted, "...the relationship between women's work and women's worth has profound consequences for their mental health".[114] Thus, some women resort to habits (such as the use of psychotropic drugs, alcohol and cigarettes) which may endanger their health. Graham notes "the physical and emotional resources necessary for caring, it seems, are secured through an

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[109] Heller, 1986.

[110] Heller, pp 12-13.

[111] C. Buck & N. Fraser-Smith, National Symposium (1988); Aronson (1986); Graham (1985); Heller (1986).

[112] Graham, p.36.

[113] Callwood, 1987.

[114] Paltiel, F.L., 1987.

edifice of health-threatening habits necessary for her own survival".[115]

The caring role in the home also restricts women's opportunities in wider society and reinforces their economic dependence. In her keynote address at the National Symposium, Carol Buck noted that with an increasing trend towards de-institutionalization, "the greatest savings would be achieved if most of the community care and social support would be provided by unpaid workers ...[specifically] women". "There looms the possibility", she remarked, "of women providing even larger amounts of informal health care than [they do] at present". This is a particularly daunting prospect when we consider that by the turn of the century, an even larger cohort of seniors will be needing care and fewer children will be available to provide it. Buck warns of the dangers of assuming a limitless supply of informal unpaid caregivers in a move towards self-help and community care.

Strategies for a better recognition of women's unpaid work include public subsidization for support mechanisms such as day care, support groups and home relief programs for women who work in the home.

3.2 WOMEN'S RELATIONSHIPS TO THE HEALTH CARE SYSTEM

3.2.1 The present organization of the health care system does not ensure the provision of appropriate health care for women.

Participants at the National Symposium on Changing Patterns of Health and Disease in Canadian Women repeatedly stated that women require more time with their health care providers, and want more information about the nature of their problem and the best way to manage it. They spoke of the need for more community-based services and a reduced tendency to provide care in institutional settings. They also spoke of the desire of many women to consult female physicians.

However, a number of barriers which reduce progress in achieving these objectives exist. The fee-for-service structure for paying physicians which characterizes the provincial health insurance plans does not encourage the required time for women to explain the complexities of their health problems or feel that all questions have been satisfactorily addressed. In an attempt not to take up more of the doctor's time, women may try to squeeze in their personal concerns at the end of appointments with children.

In most parts of the country, emphasis in health service provision is on acute or episodic services provided by hospitals. Most training of health care professionals occurs in hospitals, not in the community or in homes where most people spend most of their time. One reason for this problem is that public funding of hospitals preceded that of the community health sector in this country. While there is a gradual shift occurring away from hospitals to more community-based

[115] Graham, p.39.

services, the process is slow and many questions remain. CLSC's in Québec, for example, while a stellar model of community-based health care, only serve 15% of the population. Women's health centres may prove to be a satisfactory option for some women but they are still relatively new in Canada. It remains to be seen whether they will be used sufficiently by women of different classes, ages and ethnic backgrounds.

3.2.2 Health research is often biased towards males and inadequately addresses women's health issues.

It has been argued that more research conducted on a variety of women's health issues and more women involved both as subjects and as investigators in scientific research are important steps in improving the health status of women. (Buck [National Symposium], Eichler [1988], Kinney [1981], Kaufert [National Symposium])

Achilles (1987) has noted that "sexism is the failure to account for differences between the sexes as well as the assumption of differences when none exist. Non-sexist research seeks to acknowledge and identify differences without the traditional assumptions of inferiority or superiority - that is, different but equal". Epidemiological research tends to favour issues of mortality and acute illnesses[116], more typical of male health patterns, over chronic illness, mental stress and fatigue and higher levels of medication use, which tend to characterize female health patterns. Eichler et al, Kaufert and many others have stressed the importance of addressing these gaps and biases in health research.

A good example of the lack of appropriate attention to the key health issues for women is the extensive research currently under way on new procedures in the field of reproductive technologies at the expense of research on the causes of infertility.[117] The technologies themselves exist and are being created in order to respond to a need created by infertility. Realistically, we need a better understanding of what is causing infertility in the first place.

Often women are significantly under-represented or not represented in research on conditions which affect both sexes. Dangers can arise when conclusions for one sex are based on the findings involving the opposite sex.[118] Similarly, drug dosages are determined, for the most part, by studies of young men. This can pose significant problems, not only because women are prescribed more drugs than men, but because women suffer proportionally more adverse reactions.[119] Women have different patterns of drug metabolism and responsiveness throughout their lifecycle which need to always be considered in determining drug dosages.

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[116] Ruzek and Hill, 1986.

[117] Thompson, National Symposium.

[118] See Eichler et al's reference to a 1988 study on recovery patterns for myocardial infarction: Pfeffer et al, *New England Journal of Medicine* 1988, 319(2): 80-85.

[119] Domecq et al.

As a result of inadequate representation of women in drug testing, the National Institute of Health and the Alcohol, Drug Abuse and Mental Health Administration in the United States announced in 1987 that applicants for federally-funded research should "consider the inclusion of women in study populations for all clinical research efforts... If women are not to be included, a clear rationale should be provided for their exclusion".

3.2.3 Women have a strong presence in the paid health care sector but wield little power and influence in health policy development and direction.

Although women occupy the majority of jobs in the health care sector[120], they tend to be stratified in the low-paying and low-status occupations. In Canada, women comprise 78% of all workers in occupations in medicine and health[121], but make up only 21% of all physicians and surgeons. Some progress is being made, however, as equal numbers of men and women are being admitted to medical schools in some provinces, even though they currently make up less than half of all medical specialities. It is noteworthy, however, that as women are beginning to make some gains as physicians, there are pressures from several sources to restrict the numbers of medical school admissions. In addition, the road for women entering the profession is not always a smooth one. A survey of women physicians conducted by the Women's Issues Committee of the Ontario Medical Association found that 85% to 90% of those surveyed felt that at one time or another during their career, their sex counted against them.[122]

Women have not achieved equality with men in their representation in halls of power in health care. Given that women make up a majority of providers and consumers of health care, their proportionately low representation in senior decision-making positions and as members of influential boards and committees is of some concern.

Women's social and economic realities often dictate that they bring to the health care environment a different style of process and management. Women have developed unique coping strategies, innovative concepts and approaches to health care delivery which can provide useful models for other target groups as well as for other decision-makers. In the creation of women's health collectives and women's health centres, women have encouraged a model of operation which is non-hierarchical and encourages mutual support rather than dependency on health professionals. Indeed, the concepts of self-help and collective functioning have been an integral part of the women's health movement. The female voice and the female experience require equal representation in areas of decision-making in health care.

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[120] *Statistics Canada*, 1986 Census; (*Selected Data*, Table 27).

[121] ibid.

[122] Quoted in *Ontario Medicine*, June 19, 1989.

4. STRATEGIES FOR IMPROVING WOMEN'S HEALTH

The Canada Health Act states that the primary objective of Canadian health care policy is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers".[123] Further, the Ottawa Charter for Health Promotion states that "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health", and that "this must apply equally to women and men".[124]

Women have unique health care needs resulting from their social and economic status in Canadian society and from their biology. In order to best address the health care needs of Canadian women, policies which respond to their unique issues are required. To begin to create a vision of what such policies might look like, the changes which are needed must be examined. Borrowing from the language of Canada's framework for health promotion, *Achieving Health for All*, strategies are identified which will help in the shift towards a new vision for women's health in Canada.

4.1 FOSTERING THE PARTICIPATION OF WOMEN

Women will only begin to feel they can assert control over the factors which affect their health when they can become involved in the process which creates or influences those factors. For this to come about, women of all ages, races, economic levels, religions, languages, cultures, literacy levels, ability/disability and regions of Canada must be involved in the creation and implementation of programs, policies and services related to their health care. This was one of the most frequently repeated strategies at the National Symposium on Changing Patterns of Health and Disease in Canadian Women in 1988. The importance of asking women about their needs, as well as involving them in the needs assessment process was also stressed.

Forward-Looking Strategies from PAHO (1986) called for the need to ensure "the active participation of communities, especially women and women's organizations in planning, implementing and evaluating national health programs". As consumers of health care services and programs, equitable representation of females and males is needed on hospital boards and community advisory boards, as well as on provincial and federal boards, committees and councils.

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[123] *Canada Health Act*. Chapter C-6, Section 3. 1984.

[124] *Ottawa Charter for Health Promotion*, adopted at An International Conference on Health Promotion, organized by the World Health Organization, Health and Welfare Canada and the Canadian Public Health Association, November 17-21, 1986, Ottawa.

This principal applies at the very personal level, in that women need to be more involved in decisions about their own health care, and in their relationships with their health care providers. The appropriate conditions must be present in order for women to feel welcomed in becoming partners in decision-making regarding their health care. This principal also applies to the most senior levels of decision-making in that women need to be better represented in hospital and health care administration, medical and health research and funding bodies, and at senior government levels[125] where health care decisions are made. At the Forty-Second World Health Assembly in 1989, members noted "...the need to ensure that a women's perspective is reflected in the policies and programs of the health and other sectors affecting the health of women".[126]

Progress is being made on this front. For example, in Alberta, a Job Enhancement Advisory Committee has been set up to advise the Minister on initiatives in Alberta hospitals and nursing homes to promote the retention and job satisfaction of nursing personnel. Similarly, in Ontario, moves are underway to make changes to the Public Hospitals Act to allow nurses more involvement and power on hospital committees and boards[127].

Fostering the participation of women also means recognizing and validating the significant contribution women already make to both the formal and informal health care of Canadians. The wealth of knowledge which women possess as a result of their roles as "health guardians in the home" can be called upon in the creation of policies and programs appropriate for the needs of women and of families.

4.2 BUILDING AND STRENGTHENING APPROPRIATE HEALTH SERVICES FOR WOMEN

All Canadian women need access to appropriate and affordable quality health care services as well as information and education on how to maintain their health and well-being. It is imperative that health services for women be designed with women's needs in mind.

Paragraph 155 from the Nairobi Forward-Looking Strategies states that "appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable. Services should be in harmony with the timing and patterns of women's work, as well as with women's needs and perspectives. Maternal and child-care facilities, including family-planning services, should be within easy reach of all women. Governments should also ensure that women have the same access as men to affordable, curative, preventive and rehabilitative treatment".

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[125] In Manitoba, for example, women represent 63% of all management positions in the provincial department of health, but only 32% of senior management positions. Although data were not available from all provinces, it is assumed that this picture is fairly typical.

[126] Proceedings from the Forty-Second World Health Assembly, May 19, 1989, Geneva. Agenda item 18.2, "Women and health".

[127] Kenna, 1988.

Some women and some medical researchers may define women's health needs differently. As Ruzek and Hill (1986) have noted, medical definitions of need, usually based on epidemiological data, indicate the "interventions are called for when the condition is significant" [128]. Their concern is that the notion of significance and a determination of what will be studied may have subjective elements which may not always be to women's benefit. For example, days of work lost is often a measure used to define the degree of severity of a particular health issue. In that many women often spend many years out of the paid labour force because of their roles in child-bearing and child-rearing, this becomes an inappropriate measure to use for an accurate picture of women's health concerns. An additional problem is that much current epidemiological research places little emphasis on the chronic and debilitating conditions which characterize many women's lives.

Kaufert (National Symposium, 1988) argues that what is needed is a new way of thinking about epidemiology. Epidemiology is defined as "the study of the distribution and determinants of health-related states and events in populations, and the application of this study to the control of health problems".[129] Kaufert notes that "experiential knowledge is usually seen as quite separate from scientific knowledge, but the development of a feminist epidemiology depends on bringing them together", and adds that "by discounting subjective data, the experience of women gets left out of epidemiological research".[130]

Women's health policies must be based on accurate data and research concerning women's health which has incorporated women's own views of their health into the gathering of epidemiological data. Women's health policy which will serve women's needs would address the gaps which currently exist in women's health research through:

* the establishment of protocols free of sexist bias[131]
* the appropriate allocation of funds for women's health research in areas other than obstetrics and gynaecology.
* the more equitable involvement of women in decisions regarding funding priorities and allocations for research.[132]
* gender sensitivity in all calls for research proposals funded by provincial and federal governments

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[128] Ruzek and Hill, p.302.

[129] Last, J.M. *Maxcy-Rosenau, Public Health and Preventive Medicine*. (12th edition) Appleton-Century-Crofts, 1986. p.10.

[130] Kaufert, P. "Ensuring Our Voice is Heard: Knowledge, Coping and Control" from the National Symposium on Changing Patterns of Health and Disease in Canadian Women, April, 1988.

[131] Such protocols are not known to exist in the health sector, but a model to consider is that created for the Social Sciences and Humanities Research Council of Canada (Eichler and Lapointe, 1985).

[132] For more on this, see Kaufert's address to the National Symposium, "Ensuring Our Voice is Heard: Knowledge, Coping and Control".

Strategies regarding research emerged from Canada's National Symposium (1988). In addition to those strategies noted above, they included: the development of a proposal to the Federal Cabinet to seek dedicated funds for strategic grants for women's health issues within a feminist framework; the strengthening of links between funding bodies and grassroots and community groups; and 50% participation of women on committees deciding research priorities in health and social policy.

Another essential element to building and strengthening appropriate health services for women is the creation and maintenance of focal points for women's health at the provincial, territorial and federal levels. The purpose of such centres would be to advise, develop, assess, implement, co-ordinate and report on a wide range of policies and programs to ensure the promotion and preservation of women's health. This role is filled at the federal level in large part by the Office of the Senior Adviser, Status of Women in Health and Welfare Canada.[133] In the provinces of Ontario (the Women's Health Bureau) and Québec (Service à la condition féminine) units with dedicated government funding can act as both advocates for women's health groups and policy advisors on women's health issues within their ministries of health. The province of Manitoba is also currently in the process of expanding the mandate of the Maternal and Child Health Directorate within the Department of Health to include a broader range of women's health issues.

Gender sensitivity in the training of health care professionals will help in improving health services for women. This must apply to both their professional training and to their continuing education.

Finally, both in the role of looking after their own health and well-being and that of family members, women are heavy consumers of health education materials. Efforts must continue to be made to make materials readable[134] and accessible to women of different backgrounds. As noted earlier, it is important that the women for whom such materials are intended be involved in designing the form they should take. As Ruzek and Hill have noted "...women must be the architects as well as the builders and users of health education and promotion schemes".[135]

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[133] "The Senior Adviser is the key advisory and co-ordinating position responsible for the development, continuous assessment, implementation and integration of a range of policies and programs to ensure the promotion and preservation of the health, social security and social welfare of Canadian women and their families. She chairs the Standing Departmental Advisory Committee on Status of Women Concerns to ensure effective co-operation by all branches in the achievement of departmental and federal goals and to encourage the assumption by branch managers of responsibility for status of women matters under their jurisdiction. The Senior Adviser's role includes an educational and interpretive one nationally and internationally. The Office has been designated as a Canadian Focal Point for the Pan American Health Organization's Program on Women, Health and Development." (from *Proceedings from the National Symposium on Changing Patterns of Health and Disease in Canadian Women*, 1989)

[134] A good example of readable women's health information is *Taking Care: A Handbook About Women's Health* by Mary J.Breen, a resource funded by Health and Welfare Canada in 1988.

[135] Ruzek, S. and J.Hill, 1986. p.302.

4.3 CO-ORDINATING HEALTHY PUBLIC POLICY

Healthy public policy is achieved when all sectors, both inside and outside the health care system recognize their links to health and the importance of "intersectoral co-ordination".[136] With respect to women's health, this involves the notion that, for example, improved employment policies can create better working conditions and opportunities for women, that increased educational opportunities for women can contribute to their overall self esteem, or that improved pension programs for Canada's senior population could mean that more older women can have healthier diets and perhaps enjoy a better quality of life. The creation of healthy public policy involves a concerted effort on the part of all involved both inside and outside of the health sector and involves the need for a focal point from which such activity and policy can be co-ordinated.

Consider the example of violence against women, identified earlier as an important women's health issue. In addition to the important role played by the health care sector, healthy public policy related to violence against women must involve: the justice sector, to improve legislative measures to deal with offenders; the education sector, to educate children that this is unacceptable and criminal behaviour and to create positive role models for young boys and girls; the housing sector, to create safer living environments for women; the transportation sector, to create safer climates on modes of public transit; the employment sector, to improve workplace health services and Employee Assistance Programs; and the social services sector, to provide improved programs for the abused and the offenders.

Within the health care sector itself, there is also the possibility for intersectoral co-ordination to create healthy public policy. Health care settings could serve as models for affirmative action programs by setting an example in their hiring of women and other minorities in positions of visibility and authority. Hospitals could create workplace day care centres and adopt other policies to help both male and female staff to better integrate work and family responsibilities.

By examining the strategies outlined in this section, policies for women's health in Canada which address the challenges identified earlier can be developed. In order for such policies to be effective, women from all walks of Canadian life must be involved in their creation and sectors beyond health care must acknowledge their role in creating healthy public policy.

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[136] Pederson et al, 1988.

5. RECOMMENDATIONS
OF THE FEDERAL / PROVINCIAL / TERRITORIAL WORKING GROUP ON WOMEN'S HEALTH

In order to improve the health and well-being of all Canadian women, the Working Group recommends that:

1. EACH JURISDICTION ADOPT THE FOLLOWING GUIDING PRINCIPLES IN THE DEVELOPMENT OF POLICIES AND PROGRAMS ON WOMEN'S HEALTH:

A. ADDRESS THE SOCIAL AND ECONOMIC INEQUITIES OF WOMEN'S LIVES

- women are poorer than men
- women experience more violence
- women experience discrimination;

B. FOSTER GREATER PARTICIPATION AND EFFECTIVE REPRESENTATION IN PLANNING AND PROGRAM DELIVERY

- women constitute 80% of workers in the paid health care sector, but few of the decision makers;

C. RECOGNIZE AND SUPPORT WOMEN'S ROLES AS CAREGIVERS

- women provide most formal and informal health care services
- women have a double workload in the home and paid workforce;

D. FOSTER A COMPREHENSIVE, INTEGRATED MODEL OF HEALTH SERVICES FOR WOMEN

- the current health care system (acute, episodic, fragmented care) is inappropriate for women's health needs
- a greater emphasis on health promotion and disease prevention is essential, and

E. PRESERVE AND RESPECT THE DIVERSITY OF WOMEN

- women with disabilities, indigenous and immigrant women as well as women of colour experience multiple barriers to achieving health.

2. EACH JURISDICTION ESTABLISH OR STRENGTHEN A MECHANISM WHICH IS ACCOUNTABLE FOR WOMEN'S HEALTH THAT HAS THE ADEQUATE MANDATE, AUTHORITY AND RESOURCES TO

A. DEVELOP A FIVE-YEAR ACTION PLAN (1991 - 1996) BASED ON THE STRATEGIES DESCRIBED IN THIS REPORT, AND

B. FACILITATE THE DEVELOPMENT, CO-ORDINATION AND IMPLEMENTATION OF POLICIES AND PROGRAMS.

3. EACH JURISDICTION RECOGNIZE WOMEN'S GROUPS AND VOLUNTARY ORGANIZATIONS AS ESSENTIAL PARTNERS AND COLLABORATE WITH THEM IN PLANNING AND PROVIDING SERVICES TO WOMEN.

4. EACH JURISDICTION ENSURE CONTINUING REPRESENTATION AND COMMITMENT TO INTER-JURISDICTIONAL COLLABORATION IN

A. ADDRESSING WOMEN'S HEALTH CONCERNS, AND

B. MONITORING THE IMPLEMENTATION OF THE STRATEGIES AND RECOMMENDATIONS IN THIS REPORT.

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7. GLOSSARY

Active Living: A term proposed by Fitness Canada to replace fitness or exercise. Active living is defined as a) a variety of physical activities incorporated into one's daily routine and habits, b) the processes, experiences, and other benefits involved in and related to being physically active and c) the notion that being physically active is part of lifelong, self-empowering, developmental process aimed at maximizing one's potential. (Fitness Canada. *A Framework for Active Living and Health* (Draft). April 1989.)

Allopathic Medicine: A system of medical practice which combats disease by treatments which produce effects different from those produced by the disease being treated. The term is generally used to refer to most aspects of conventional medicine (surgery, pharmacology, etc.) in contrast with alternative forms of treatment.

Alternative Health Care: This term embraces both alternative health therapies, such as alternatives to allopathic medicine (vitamin therapy, chiropractic, naturopathy, acupuncture, herbalism), as well as alternative methods of health care delivery such as midwifery versus traditional obstetrics or health service organizations and community health centres versus hospitals and private practices.

Birthing Centre: This term is used to refer to an actual site for childbirth as well as a philosophy of childbirth. The purpose of a birthing centre is to create an environment that is homelike, private, comfortable and relaxed with minimal obstetrical intervention. Birthing centres in Canada are currently all within hospitals but free-standing birthing centres can be found in many parts of the United States and Europe.

Disability: The World Health Organization defines disability as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being". (*WHO Classification of Impairments, Disabilities and Handicaps*. Geneva:WHO, 1980).

Empowerment: The verb "to empower" is defined as the ability to choose or to increase one's capacity to define, analyse and act upon one's problems. (G.Kent. "Nutritional education as an instrument of empowerment ". *Journal of Nutrition Education*, Vol. 20(4), 1988.) It has been noted by others (Labonte, 1988) that one cannot empower someone else, but can provide the tools and information to help someone empower themselves.

Guardians of Healthcare in the Home: This term was used in the 1986 report of the Canadian Advisory Council on the Status of Women (Heller), *Health and Home: Women as Health Guardians*, to describe the role of women which comprises the "physical and psychological activities of home-based health care". This work includes the home care of ill family members, the arrangement of health care appointments, the maintenance of a risk-free and healthy environment, and the health education of family members.

Health Promotion: Health promotion is the process of enabling individuals and communities to

increase control over the determinants of health and thereby improve their health. It represents a mediating strategy between people and their environments, involving public participation in the definition of problems, decision-making and action taken to change the determinants of health. (Don Nutbeam. "Health promotion glossary". *Health Promotion*. Vol 1(1), 1986.)

Healthy Public Policy: This notion incorporates a broad vision of health, and crosses traditional departmental and ministerial boundaries to involve sectors outside the health care system. It is characterized by concern for health and equity in all areas of policy. The concept of healthy public policy recognizes that there is a wide range of influences on health which are not limited to the health sector.

Mainstream: The term is used to make a distinction between groups or services which are intended for a specific (usually disadvantaged or under-serviced) group and those which are intended to serve the general population. For example, the YWCA would be considered a mainstream group or service since it is intended for "all" persons in the community, whereas an immigrant women's centre would not be a mainstream group or service.

Women's Health Movement: The women's health movement is a social movement of individuals, mostly women, and women's organizations who seek to promote and improve the health care of women.

APPENDIX A

THE NAIROBI FOWARD-LOOKING STRATEGIES FOR THE ADVANCEMENT OF WOMEN

Adopted at the Conference to Review and
Appraise the Achievements of the United Nations
Decade for Women: Equality, Development and Peace.

Nairobi, Kenya
July 15-16, 1985

EXTRACTS OF THE HEALTH-RELATED PARAGRAPHS

By the Office of the Senior Adviser Status of Women

Health and Welfare Canada
April 1988

B. Substantive background of the forward-looking strategies

Paragraph 15

The three goals of the Decade - equality, development and peace - are inextricably linked to the three sub-themes - employment, health and education. They constitute the concrete basis on which equality, development and peace rest. The enhancement of women's equal participation in development and peace requires the development of human resources, recognition by society of the need to improve women's status, and the participation of all in the restructuring of society. It involves, in particular, building a participatory human infrastructure to permit the mobilization of women at all levels, within different spheres and sectors. To achieve optimum development of human and material resources, women's strengths and capabilities, including their great contribution to the welfare of families and to the development of society, must be fully acknowledged and valued. The attainment of the goals and objectives of the Decade requires a sharing of this responsibility by men and women and by society as a whole and requires that women play a central role as intellectuals, policy-makers, decision-makers, planners, and contributors and beneficiaries of development.

C. Current trends and perspectives to the year 2000

Paragraph 25

It is feared that, if there is slow growth in the world economy, there will inevitably be negative implications for women since, as a result of diminished resources, action to combat women's low position, in particular, their high rates of illiteracy, low levels of education, discrimination in employment, their unrecognized contribution to the economy and their special health needs, may be postponed. A pattern of development promoting just and equitable growth on the basis of justice and equality in international economic relations could make possible the attainment of the goals and objectives of the International Development Strategy, which could make a significant improvement in the status of women while enhancing women's effective contribution to development and peace. Such a pattern of development has its own internal dynamics that would facilitate an equitable distribution of resources and is conducive to promoting sustained, endogenous development, which will reduce dependence.

Paragraph 33

There is no doubt that, unless major measures are taken, numerous obstacles will continue to exist which retard the participation of women in political life, in the formulation of policies that affect them and in the formulation of national women's policies. Success will depend in large measure upon whether or not women can unite to help each other to change their poor material circumstances and secondary status and to obtain the time, energy and experience required to participate in political life. At the same time, improvements in health and educational status, legal and constitutional provisions and networking will increase the effectiveness of the political action taken by women so that they can obtain a much greater share in political decision-making than before.

D. Basic approach to the formulation of the forward-looking strategies

Paragraph 41

The Forward-looking Strategies not only suggest measures for overcoming obstacles that are fundamental and operational, but also identify those that are emerging. Thus, the strategies and measures presented are intended to serve as guidelines for a process of continuous adaptation to diverse and changing national situations at speeds and modes determined by overall national priorities, within which the integration of women in development should rank high. The Forward-looking Strategies, acknowledging existing and potential obstacles, include separate basic strategies for the achievement of equality, development and peace. In line with the recommendations of the Commission on the Status of Women, acting as the Preparatory Body for the Conference at its second session, particular attention is given to "especially vulnerable and underprivileged groups of women, such as rural and urban poor women; women in areas affected by armed conflicts, foreign intervention and international threats to peace; elderly women; young women; abused women; destitute women; women victims of trafficking and women in involuntary prostitution; women deprived of their traditional means of livelihood; women who are sole supporters of families; physically and mentally disabled women; women in detention; refugee and displaced women; migrant women; minority women; and indigenous women".

I. EQUALITY

B. Basic strategies

Paragraph 54

In order to promote equality of women and men, Governments should ensure, for both women and men, equality before the law, the provision of facilities for equality of educational opportunities and training, health services, equality in conditions and opportunities of employment, including remuneration, and adequate social security. Governments should recognize and undertake measures to implement the right of men and women to employment on equal conditions, regardless of marital status, and their equal access to the whole range of economic activities.

II. DEVELOPMENT

B. Basic strategies

Paragraph 112

The actual and potential impact on women of macro-economic processes operating at the international and national levels, as well as of financial spatial and physical development policies, should be assessed and appropriate modifications made to ensure that women are not adversely affected. Initial emphasis should be placed on employment, health and education. Priority should be given to the development of human resources, bearing in mind the need to avoid further increases in the work-load of women, particularly when alternative policies are formulated to deal with the economic and debt crisis.

Paragraph 115

The gender bias evident in most development programmes should be eliminated and the prejudices hindering the solution of women's problems removed. Particular attention should be given to the restructuring of employment, health and education systems and to ensuring equal access to land, capital and other productive resources. Emphasis should be placed on strategies to assist women in generating and keeping income, including measures designed to improve women's access to credit. Such strategies must focus on the removal of legal, customary and other barriers and on strengthening women's capacity to use existing credit systems.

C. Measures for the implementation of the basic strategies at the national level

Paragraph 139

The working conditions of women should be improved in all formal and informal areas by the public and private sectors. Occupational health and safety and job security should be enhanced and protective measures against work-related health hazards effectively implemented for women and men. Appropriate measures should be taken to prevent sexual harassment on the job or sexual exploitation in specific jobs, such as domestic service. Appropriate measures for redress should be provided by Governments and legislative measures guaranteeing these rights should be enforced. In addition, Governments and the private sector should put in place mechanisms to identify and correct harmful working conditions.

Paragraph 140

National planning should give urgent consideration to the development and strengthening of social security and health schemes and maternity protection schemes in keeping with the principles laid down in the ILO maternity protection convention and maternity protection recommendation and other relevant ILO conventions and recommendations as a prerequisite to the hastening of women's effective participation in production, and all business and trade unions should seek to promote the rights and compensations of working women and to ensure that appropriate infrastructures are provided. Parental leave following the birth of a child should be available to both women and men and preferably shared between them. Provision should be made for accessible child-care facilities for working parents.

Health

Paragraph 148

The vital role of women as providers of health care both inside and outside the home should be recognized, taking into account the following: the creation and strengthening of basic services for the delivery of health care, with due regard to levels of fertility and infant and maternal mortality and the needs of the most vulnerable groups and the need to control locally prevalent endemic and epidemic diseases. Governments that have not already done so should undertake, in co-operation with the World Health Organization, the United Nations Children's Fund and the United Nations Fund for Population Activities, plans of action relating to women in health and development in order to identify and reduce risks to women's health and to promote the positive health of

women at all stages of life, bearing in mind the productive role of women in society and their responsibilities for bearing and rearing children. Women's participation in the achievement of Health for All by the 2000 should be recognized, since their health knowledge is crucial in their multiple roles as health providers and health brokers for the family and community, and as informed consumers of adequate and appropriate health care.

Paragraph 149

The participation of women in higher professional and managerial positions in health institutions should be increased through appropriate legislation; training and supportive action should be taken to increase women's enrolment at higher levels of medical training and training in health-related fields. For effective community involvement to ensure the attainment of the World Health Organization's goal of Health for All by the year 2000 and responsiveness to women's health needs, women should be represented in national and local health councils and committees. The employment and working conditions of women health personnel and health workers should be expanded and improved at all levels. Female traditional healers and birth attendants should be more fully and constructively integrated in national health planning.

Paragraph 150

Health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women's and girls' health. Steps should be taken to change the attitudes and health knowledge and composition of health personnel so that there can be an appropriate understanding of women's health needs. A greater sharing by men and women of family and health-care responsibilities should be encouraged. Women must be involved in the formulation and planning of their health education needs. Health education should be available to the entire family not only through the health care system, but also through all appropriate channels and in particular the educational system. To this end, Governments should ensure that information meant to be received by women is relevant to women's health priorities and is suitably presented.

Paragraph 151

Promotive, preventive and curative health measures should be strengthened through combined measures and a supportive health infrastructure which, in accordance with the International Code of Marketing of Breast Milk Substitutes, should be free of commercial pressure. To provide immediate

access to water and sanitary facilities for women, Governments should ensure that women are consulted and involved in the planning and implementation of water and sanitation projects, trained in the maintenance of water-supply systems, and consulted with regard to technologies used in water and sanitation projects. In this regard, recommendations arising from the activities generated by the International Drinking Water Supply and Sanitation Decade and other public health programmes should be taken into account.

Paragraph 152

Governments should take measures to vaccinate children and pregnant women against certain endemic local diseases as well as other diseases as recommended by the vaccination schedule of the World Health Organization and to eliminate any differences in coverage between boys and girls (cf. WHO report EB 75/22). In regions where rubella is prevalent, vaccinations should preferably be given to girls before puberty. Governments should ensure that adequate arrangements are made to preserve the quality of vaccines. Governments should ensure the quality of vaccines. Governments should also ensure the full and informed participation of women in programmes to control chronic and communicable diseases.

Paragraph 153

The international community should intensify efforts to eradicate the trafficking, marketing and distribution of unsafe and ineffective drugs and to disseminate information on their ill effects. Those efforts should include educational programmes to promote the proper prescription and informed use of drugs. Efforts should also be strengthened to eliminate all practices detrimental to the health of women and children. Efforts should be made to ensure that all women have access to essential drugs appropriate to their specific needs and as recommended in the WHO List of Essential Drugs as applied in 1978. It is imperative that information on the appropriate use of such drugs is made widely available to all women. When drugs are imported or exported Governments should use the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce.

Paragraph 154

Women should have access to and control over income to provide adequate nutrition for themselves and their children. Also, Governments should foster activities that will increase awareness of the special nutritional needs of women; provide support to ensure sufficient rest in the last trimester of pregnancy and while breast-feeding; and promote interventions

to reduce the prevalence of nutritional diseases such as anaemia in women of all ages, particularly young women, and promote the development and use of locally produced weaning food.

Paragraph 155

Appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable. Services should be in harmony with the timing and patterns of women's work, as well as with women's needs and perspectives. Maternal and child-care facilities, including family planning services, should be within easy reach of all women. Governments should also ensure that women have the same access as men to affordable curative, preventive and rehabilitative treatment. Wherever possible, measures should be taken to conduct general screening and treatment of women's common diseases and cancer. In view of the unacceptably high levels of maternal mortality in many developing countries, the reduction of maternal mortality from now to the year 2000 to a minimum level should be a key target for Governments and non-governmental organizations.

Paragraph 156

The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. As recognized in the World Population Plan of Action k/ and reaffirmed at the International Conference on Population, 1984, all couples and individuals have the basic human right to decide freely and informedly the number and spacing of their children; maternal and child health and family-planning components of primary health care should be strengthened; and family-planning information should be produced and services created. Access to such services should be encouraged by Governments irrespective of their population policies and should be carried out with the participation of women's organizations to ensure their success.

Paragraph 157

Governments should make available, as a matter of urgency, information, education and the means to assist women and men to take decisions about their desired number of children. To ensure a voluntary and free choice, family-planning information, education and means should include all medically approved and appropriate methods of family planning. Education for responsible parenthood and family-life education should be widely available and should be directed towards both men and women. Non-governmental organizations, particularly women's organizations, should be involved in such programmes

because they can be the most effective media for motivating people at that level.

Paragraph 158

Recognizing that pregnancy occurring in adolescent girls, whether married or unmarried, has adverse effects on the morbidity and mortality of both mother and child, Governments are urged to develop policies to encourage delay in the commencement of childbearing. Governments should make efforts to raise the age of entry into marriage in countries in which this age is still quite low. Attention should also be given to ensuring that adolescents, both girls and boys, receive adequate information and education.

Paragraph 159

All Governments should ensure that fertility-control methods and drugs conform to adequate standards of quality, efficiency and safety. This should also apply to organizations responsible for distributing and administering these methods. Information on contraceptives should be made available to women. Programmes of incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights, as well as with changing individual and cultural values.

Paragraph 160

Governments should encourage local women's organizations to participate in primary health-care activities including traditional medicine, and should devise ways to support women, especially underprivileged women, in taking responsibility for self-care and in promoting community care, particularly in rural areas. More emphasis should be placed on preventive rather than curative measures.

Paragraph 161

The appropriate gender-specific indicators for monitoring women's health that have been or are being developed by the World Health Organization should be widely applied and utilized by Governments and other interested organizations in order to develop and sustain measures for treating low-grade ill health and for reducing high morbidity rates among women, particularly when illnesses are psychosomatic or social and cultural in nature. Governments that have not yet done so should establish focal points to carry out such monitoring.

Paragraph 162

Occupational health and safety should be enhanced by the public and private sectors. Concern with the occupational health risks should cover female as well as male workers and focus among other things on risks endangering their reproductive capabilities and unborn children. Efforts should equally be directed at the health of pregnant and lactating women, the health impact of new technologies and the harmonization of work and family responsibilities.

Education

Paragraph 164

Special measures should be taken by governments and the international organizations, especially UNESCO, to eliminate the high rate of illiteracy by the year 2000, with the support of the international community. Governments should establish targets and adopt appropriate measures for this purpose. While the elimination of illiteracy is important to all, priority programmes are still required to overcome the special obstacles that have generally led to higher illiteracy rates among women than among men. Efforts should be made to promote functional literacy, with special emphasis on health, nutrition and viable economic skills and opportunities, in order to eradicate illiteracy among women and to produce additional material for the eradication of illiteracy. Programmes for legal literacy in low-income urban and rural areas should be initiated and intensified. Raising the level of education among women is important for the general welfare of society and because of its close link to child survival and child spacing.

Food, water and agriculture

Paragraph 177

The General Assembly, in resolution 39/165 on the critical situation of food production and agriculture in Africa, confirmed the growing concern of the international community at the dramatic deterioration in African food and agricultural production and the resulting alarming increase in the number of people, especially women and children, exposed to hunger, malnutrition and even starvation. Concrete measures and adequate resources for the benefit of African women should be a priority. The international community, particularly donor countries, should be urged to assist African women by continuing and, where possible, by increasing financial assistance to enhance the role of women as food producers, with an emphasis on providing training in food technologies, thereby alleviating the problems of the

continent resulting from extended drought and a severe shortage of food. Donor countries should also contribute to the special funds that have been launched by various organizations - for example, the United Nations Development Fund for Women. Emergency assistance should be increased and accelerated to alleviate the suffering of starving and dying women and children under famine conditions in Africa. Furthermore, given the critical food situation in Africa, aggravated inter alia by demographic pressures, the international community is urged to give priority to and provide support for the efforts of the African countries to overcome this serious situation. These efforts include the Lagos Plan of Action of the Nairobi Programme of Action, as well as the consultation by African Governments on the role of women in food production and food security.

Industry

Paragraph 194

In accordance with accepted international labour standards, particularly, though not exclusively, in the field of female employment, appropriate legislation should be adopted and fully implemented at the national level. Specific consideration should be given to the removal of discriminatory practices concerning employment conditions, health and safety, and to guaranteeing provisions for pregnant women and maternity benefits and child care. Social security benefits, including unemployment benefits, should be guaranteed to women on an equal footing with men. Recruitment of female workers in existing or new capital-intensive, high-productivity sectors should be encouraged.

Science and technology

Paragraph 201

The involvement of women in all of the peaceful uses of outer space should be enhanced, and effective measures should be undertaken to integrate women into all levels of decision-making and the implementation of such activities. In all countries special efforts should be made by Governments and non-governmental organizations to provide women and women's organizations with information on the peaceful uses of outer space. Special incentives should be provided to enable women to obtain advanced education and training in areas related to outer space in order to expand their participation in the application of outer space technology for peaceful uses, especially in the high-priority development areas of water, health, energy, food production and nutrition. To achieve these goals, increased opportunities and encouragement should be given to women to study science, mathematics and

engineering at the university level and to girls to study mathematics and science at the pre-university level.

Paragraph 204

The potential and actual impact of science and technology on the developments that affect women's integration into the various sectors of the economy, as well as on their health, income and status, should be assessed. Relevant findings should be integrated in policy formulation to ensure that women benefit fully from available technologies and that any adverse effects are minimized.

Paragraph 205

Efforts in the design and delivery of appropriate technology to women should be intensified, and attention should be given to the achievement of the best possible standard in such technologies. In particular, the implications of advances in medical technology for women should be carefully examined.

Housing, settlement, community development and transport

Paragraph 213

All measures to increase the efficiency of land, water and air transportation should be formulated with due regard to women as producers and consumers. All national and local decisions concerning transportation policies, including subsidies, pricing, choice of technology for construction and maintenance, and means of transport, should consider women's needs and should be based on consideration of the possible impact on the employment, income and health of women.

Energy

Paragraph 223

The involvement of women at all levels of decision-making and implementation of energy-related decisions including peaceful use of nuclear energy should be enhanced. Special efforts should be made by Governments and non-governmental organizations to provide women and women's organizations with information on all sources and uses of energy, including nuclear energy. Special incentives should be provided to enable women to obtain advanced levels of education and training in all energy-related areas in order to expand their participation in decision-making relating to the application of nuclear technology for peaceful uses especially in high

priority development areas of water, health, energy, food production and nutrition. To achieve these goals, increased opportunities and encouragement should be given to women to study science, mathematics and engineering at the university level and for girls to study mathematics and science at the pre-university level.

Environment

Paragraph 225

Efforts to improve sanitary conditions, including drinking water supplies, in all communities should be strengthened, especially in urban slums and squatter settlements and in rural areas, with due regard to relevant environmental factors. These efforts should be extended to include improvements of the home and the work environment and should be effected with the participation of women at all levels in the planning and implementation process.

Social services

Paragraph 229

Governments should further establish ways and means of assisting women consumers through the provision of information and the creation of legislation that will increase consumer consciousness and protect consumers from unsafe goods, dangerous drugs, unhealthy foods and unethical and exploitative marketing practices. Non-governmental organizations should work towards establishing strong and active organizations for consumer protection.

Paragraph 230

Public expenditure directed towards health, education and training and towards providing health-care and child-care services for women should be increased.

IV. AREAS OF SPECIAL CONCERN

C. Elderly women

Paragraph 286

The International Plan of Action on Aging adopted by the World Assembly on Aging in 1982 s/ emphasized both the humanitarian and developmental aspects of aging. The recommendations of the Plan of Action are applicable to women and men with a view to providing them with protection and

care, and ensuring their involvement and participation in social life and development. However, the Plan of Action recognizes a number of specific areas of concern for elderly women since their longer life expectancy frequently means an old age aggravated by economic need and isolation for both unmarried women and widows, possibly with little or no prospect of paid employment. This applies particularly to those women whose lifetimes were spent in unpaid and unrecognized work in the home with little or no access to a pension. If women have an income, it is generally lower than men's, partly because their former employment status has in the majority of cases been broken by maternity and family responsibilities. For this reason, the Plan of Action also noted the need for long-term policies directed towards providing social insurance for women in their own right. Governments and non-governmental organizations should, in addition to the measures recommended, explore the possibilities of employing elderly women in productive and creative ways and encouraging their participation in social and recreational activities.

It is also recommended that the care of elderly persons, including women, should go beyond disease orientation and should include their total well-being. Further efforts, in particular primary health care, health services and suitable accommodation and housing as strategies should be directed at enabling elderly women to lead a meaningful life as long as possible, in their own home and family and in the community.

Women should be prepared early in life, both psychologically and socially, to face the consequences of longer life expectancy. Although, while getting older, professional and family roles of women are undergoing fundamental changes, aging, as a stage of development, is a challenge for women. In this period of life, women should be enabled to cope in a creative way with new opportunities. The social consequences arising from the stereotyping of elderly women should be recognized and eliminated. The media should assist by presenting positive images of women, particularly emphasizing the need for respect because of their past and continuing contributions to society.

Attention should be given to studying and treating the health problems of aging, particularly in women. Research should also be directed towards the investigation and slowing down of the process of premature aging due to a lifetime of stress, excessive work-load, malnutrition and repeated pregnancy.

D. Young women

Paragraph 287

Initiatives begun for the 1985 International Youth Year should be extended and expanded so that young women are protected from abuse and exploitation and assisted to develop their full potential. Girls and boys must be provided with equal access to health, education and employment to equip them for adult life. Both girls and boys should be educated to accept equal responsibilities for parenthood.

Urgent attention should be paid to the educational and vocational training of young women in all fields of occupation, giving particular emphasis to those who are socially and economically disadvantaged. Self-employed young women and girls should be assisted to organize co-operatives and ongoing training programmes to improve their skills in production, marketing and management techniques. Special retraining programmes should also be developed for teenage mothers and girls who have dropped out of school and are ill equipped to enter productive employment.

Steps should be taken to eliminate exploitative treatment of young women at work in line with ILO Convention No. III concerning discrimination in respect of employment and occupation, 1958 and ILO Convention No. 122 concerning employment policy, 1964. Legislative measures guaranteeing young women their rights should be enforced.

Governments should recognize and enforce the rights of young women to be free from sexual violence, sexual harassment and sexual exploitation. In particular, Governments should recognize that many young women are victims of incest and sexual abuse in the family, and should take steps to assist the victims and to prevent such abuse by education, by improving the status of women and by appropriate action against offenders. Young women should be educated to assert their rights. Particular attention should also be given to sexual harassment and exploitation in employment, especially those areas of employment such as domestic service, where sexual harassment and exploitation are most prevalent.

Governments must also recognize their obligation to provide housing for young women who because of unemployment and low incomes suffer special problems in obtaining housing. Homeless young women are particularly vulnerable to sexual exploitation.

In the year 2000 women aged 15-24 will constitute over 8 per cent of both rural and urban populations in developing countries. The great majority of these women will be out of school and in search of jobs. For those employed, frequent exploitation, long working hours and stress have serious

implications for their health. Low nutritional levels and unplanned and repeated pregnancies are also aggravating factors.

E. Abused women

Paragraph 288

Gender-specific violence is increasing and Governments must affirm the dignity of women, as a priority action.

Governments should therefore intensify efforts to establish or strengthen forms of assistance to victims of such violence through the provision of shelter, support, legal and other services.

In addition to immediate assistance to victims of violence against women in the family and in society, Governments should undertake to increase public awareness of violence against women as a societal problem, establish policies and legislative measures to ascertain its causes and prevent and eliminate such violence, in particular by suppressing degrading images and representations of women in society, and finally encourage the development of educational and re-educational measures for offenders.

J. Women with physical and mental disabilities

Paragraph 296

It is generally accepted that women constitute a significant number of the estimated 500 million people who are disabled as a consequence of mental, physical or sensory impairment. Many factors contribute to the rising numbers of disabled persons, including war and other forms of violence, poverty, hunger, nutritional deficiencies, epidemics and work-related accidents. The recognition of their human dignity and human rights and the full participation by disabled persons in society is still limited, and this presents additional problems for women who may have domestic and other responsibilities. It is recommended that Governments should adopt the Declaration on the Rights of Disabled Persons (1975) and the World Program of Action concerning Disabled Persons (1982) which provide an overall framework for action and also refer to problems specific to women that have not been fully appreciated by society because they are still not well known or understood. Community-based occupational and social rehabilitation measures, support services to help them with their domestic responsibilities, as well as opportunities for the participation of such women in all aspects of life should be provided. The rights of intellectually disabled women to obtain health information and advice and to consent to or

refuse medical treatment should be respected; similarly, the rights of intellectually disabled minors should be respected.

N. Minority and "indigenous" women

Paragraph 303

Governments should ensure that the fundamental human rights and freedoms as enshrined in relevant international instruments are fully guaranteed also to women belonging to minority groups and indigenous populations. Governments in countries in which there are indigenous and minority populations should ensure respect for the economic, social and cultural rights of these women and assist them in the fulfilment of their family and parental responsibilities. Specific measures should address dietary deficiencies, high levels of infant and maternal mortality and other health problems, lack of education, housing and child care. Vocational, technical, professional and other training should be provided to enable these women to secure employment or to participate in income-generating activities and projects, and to secure adequate wages, occupational health and safety and their other rights as workers. As far as possible, Governments should ensure that these women have access to all services in their own languages.

V. INTERNATIONAL AND REGIONAL CO-OPERATION

C. Measures for the implementation of the basic strategies

Paragraph 329

In allocating multilateral and bilateral assistance, agencies, in consultation with recipient Governments, should establish measurable and reviewable plans of action, with goals and time frames. They should also give adequate impetus to sustained and real increases in the flow of resources for technical co-operation activities of benefit to women, including greater mobilization of resources from non-governmental sources and the private sector. Bilateral and multilateral aid agencies should give special consideration to assisting the least developed countries in their efforts to integrate women in development. In this regard, particular attention should be given to projects in the fields of health, education and training, and the creation of employment opportunities for women, especially in rural areas.

Appendix B

Historical Perspectives on Women's Health In Canada

For the last two decades in Canada, women have been increasingly expressing their concern about the shortcomings in the health care system with respect to meeting the needs of women. Lobby groups, health networks, women's health groups in communities of all sizes, and a national women's health quarterly[137] have raised awareness about the problems which women encounter with the current health care delivery system.

Women's Health History in Canada

An early history of women healers and midwives who derived their knowledge from apprenticeship and oral tradition characterized Native communities as well as settlements in French and English Canada[138]. In many areas of Canada, the mother or grandmother served as doctor, nurse and apothecary for the whole family.[139] A little publicized fact of Canadian history is that the first hospital in Canada, the Hôtel Dieu in Québec City, was founded by a group of women, in this case the Augustine nuns of Dieppe, France, in 1639. In 1641, Jeanne Mance founded the Hôtel Dieu in Montréal.

With the institutionalization of health care and the growing scientific focus of medicine in the 18th century, the more holistic role which women had played began to lose its importance. For example, in 1795, a group of physicians persuaded the legislative assembly of Upper Canada to include midwifery - once the sole domain of lay women - into the definition of medical arts which could be legally performed only by licenced physicians.

Since the beginning of the nineteenth century, the medical profession has played a dominant role in shaping Canadian health care services. This dominance has been based primarily on the premise of exclusive jurisdiction for the rendering of many key services and the control of boundaries for other health professions.[140] Women who had acted as independent practitioners were now relegated to subordinate positions[141], denied access to medical training, and utilized as

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[137] *Healthsharing*, a Canadian Women's Health Quarterly, in operation since 1979.

[138] *Report of the Task Force on The Implementation of Midwifery in Ontario* (1987), Appendix 1: "A History of Midwifery in Canada" by Jutta Mason.

[139] Coburn, Judi. "I see and I am silent. A short history of nursing in Ontario 1850-1930" in Coburn, D'Arcy, New and Torrance, *Health and Canadian Society*.

[140] For elaboration, see York (1987), Taylor (1960), DeVries (1986), Wilinsky (1964) and Torrance (1981).

[141] See R. Warburton and W.K. Carroll, "Class and gender in nursing" in B. Singh Bolaria and H.D. Dickinson, eds. (1988), p. 370.

an "inexpensive labour force".[142] Their seemingly "frail and unpredictable" nature was often touted as the reason for their exclusion from the profession.[143] In 1867, Emily Stowe became the first woman to practise medicine in Canada after having been forced to pursue her medical studies in the United States, since Canadian medical schools did not admit women. Along with other Canadian suffragists, she subsequently fought for the right of women to study and practise medicine in Canada, and eventually saw her daughter, Augusta, become the first woman to graduate from a Canadian medical school in 1883.

Women also attempted to respond to the increasing needs of a developing nation with the creation of such diverse organizations as The Temperance League, The National Council of Women, The Young Women's Christian Association, The Social Service Council of Canada and the Victorian Order of Nurses.

The first formally trained nurses to come to Canada arrived in the early 17th century as members of religious orders and, as previously noted, were responsible for the establishment and management of several hospitals in Québec and Ontario. By the end of the 19th century, nurses were actively lobbying to gain recognition as a profession with its ensuing rights and privileges.[144] In 1907, the Canadian National Association of Nurses (precursor to the Canadian Nurses Association) was established and Nurses Acts were passed in all existing provinces around the same time.

The education of nurses in Canada dates back to 1874. Although the first university degree programme in nursing was established at the University of British Columbia in 1919, seventy years later there is still no formalized PhD in Nursing program in Canada.[145]

In 1905, Catholic nuns opened the Caughnawaga Kateri Memorial Hospital Centre on reserve land near Montréal and ran the Centre for fifty years until their religious order went bankrupt. At that time, a group of Caughnawaga's Mohawk Indians, led by a woman, Louise McComber, kept the hospital from closure.[146] In 1911, a group of pioneering women established Toronto's Women's College Hospital as a seven-bed hospital specializing in women's health

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[142] See Wootherspoon, Terry, "Training and containing nurses: The development of nursing education in Canada" in B. Singh Bolaria and H.D. Dickinson, eds (1988), p. 370.

[143] An astonishing array of ill-informed theories about the female constitution prevailed throughout the 17th and 18th century . Biological differences were frequently used as a rationale for social differences, including the need for "separate spheres" - men in the public sphere (the workplace) and women in the private sphere (the home). Victorian women who displayed signs of non-conformity or rebelliousness were labelled hysterical (of the same root as "uterus") and were commonly treated for their "illness" with the removal of a vital organ such as the clitoris, ovaries or uterus (Barker-Benfield). This practice is seen by some to have its contemporary manifestation in the high rates of tranquillization and electroshock therapy performed on women who do not "fit in".

[144] One historian has noted that throughout time, "the main aim of hospital nursing schools has been to provide hospitals with cheap labour" (P.M. Jensen, *New Canadian Encyclopedia*, "Nursing").

[145] However, McGill and the University of Alberta have a small number of special status students beginning such studies (based on personal communication with Education Director of the Canadian Nurses Association, Ottawa, Sept. 22, 1989).

[146] Greacoe, Paul. "A nation's disgrace" in Coburn, D'Arcy, New and Torrance (1981), p.120.

problems and offering a place for women physicians to practise. In 1932, Mary E. Hawkins established the first Canadian birth control clinic in Hamilton.[147]

The dominance of the medical profession, the suppression of female lay healers and midwives, and the lack of access to adequate services have remained major concerns of those working towards improvements in women's health over the last two decades. The issue which has generated a women's health movement in most countries has been that of reproductive control. This includes access to safe and effective birth control and abortion services. Increased medical intervention in the birth process, as reflected by the alarming rise in Cesarean section rates in Canada (from 8% in the early 1970s to 19% in the mid-1980s), has also been a major focus of attention and activity of the women's health movement. Women's mental health issues, including concern with addictions and the high prescription rate of psychotropic drugs to women, have also been a focus of concern.

Concurrent with the movement to improve health care services for women has been an effort to see more women entering medical schools and senior positions in health care management as well as an attempt to give more prominence to the role of nurses. In all the specialties of medicine, women have yet to achieve parity with men. While women represent close to a third of all pediatricians in Canada (31.5%), they make up as few as 14% of all obstetricians and gynaecologists.[148]

Since the late 1960s, a growing awareness about women's health issues has been evident at both a community level - in what one might call the women's health movement -and at a more structured government level. (For more on women's health activities at the federal government level, see Appendix C on page 76.)

A Movement Towards the Improvement of Women's Health in Canada[149]

Signs of an emerging women's health movement began to appear in the late 1960s in Canada. In 1968, when the practice of disseminating birth control was still illegal in Canada, the Montréal Health Press produced *The Birth Control Handbook* as a response to the urgent need for accessible information about birth control and a punitive and regressive law. In 1972, the Vancouver Women's Health Collective was formed, offering women's self-help groups and a doctor referral directory. Its aim was to provide "a critique, but not a substitute for the traditional health-care system". A primary goal of the health collective, as with other women's health collectives and groups, has been to de-mystify the medical aspects of women's health and teach women about their bodies. The Boston Women's Health Book Collective's *Our Bodies, Our Selves*, first published in 1971, was a milestone document in encouraging this new orientation of helping women to better

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[147] Dodd, Dianne. "The Canadian Birth Control Movement on Trial 1936-1937" in *Social History*, Vol XVI, No. 32, November 1983, p. 413.

[148] *Selected Specialties from the Royal College of Physicians and Surgeons of Canada, Fellows in Good Standing as of September, 1989.* [see Appendix C below]

[149] Note that the term "movement" is used in a very broad sense here. Individuals involved in the women's health movement do not constitute a homogeneous group; they are consumers, health care providers, feminist activists, academics and social service providers and come from a wide range of backgrounds. There is no central co-ordinating body or information clearinghouse, but rather a number of individuals, groups and networks in all parts of Canada.

understand their bodies.

By the late 1970s, a series of centres de santé des femmes had been established across the province of Québec. They have offered alternative forms of treatment and have served as models for other women's health centres across the country. In addition to providing clinical, support and education services for women, the centres have been an integral part of the mechanism to improve access to abortion in Québec. The Fédération du Québec pour le planning des naissances and the Coalition québécoise pour le droit à l'avortement libre et gratuit have been two other organizations which have worked towards the enhancement of women's reproductive rights in Québec. In the area of birth and pregnancy, a provincial network known as Naissance-Renaissance has been lobbying since 1977 for the humanization of medical care and towards the establishment of birthing centres and the legalization of midwifery.

During the same decade, the Women's Health Education Network in Nova Scotia had set up "well women" clinics around the province. By 1980, *Healthsharing* magazine had commenced publication and women's health networks had been established in a number of cities and towns across the country. In May of 1981, a community-based women's health clinic began operating in Winnipeg, the first in English Canada. Since 1986, a regionally-representative, co-ordinating committee has been working towards the establishment of a Canadian Women's Health Network whose aim would be to link the efforts and information of those involved in women's health activities across Canada.

In addition to the creation of the Canadian Women's Health Network, an equally ambitious project of the women's health movement in the past decade has been the development and tour of "Side Effects: A Play About Women and Pharmaceuticals". The play evolved out of a national workshop on women and pharmaceuticals held in 1983 and toured Canadian communities from coast to coast where it was seen by an estimated 10,000 people. The results were impressive: in Manitoba, a women's health network grew out of the tour; following the showing in Thunder Bay, women started a "buddy" system to help each other better handle visits to their physician; and in Terrace, B.C., the local women's centre sponsored a workshop on global health issues as a result of the play.

In 1987, a committee of the Canadian Mental Health Association released an extensive report on women's mental health issues in which a number of strategies for change were put forward. One outcome of that effort was a national conference on women and mental health held in Banff in May of 1989 with women representing both grassroots and professional perspectives attending from across Canada.

The women's health movement, in Canada as in other countries[130], is integrally linked to other consumer and advocacy movements and is part of a larger movement towards the improvement of the status of women. The health promotion movement in Canada has recognized the role the women's health movement has played in popularizing self-care and community

[130] ISIS International (Rome, Italy), The Latin American and Caribbean Women's Health Network (Santiago, Chile), the Women's Global Network for Reproductive Rights (Amsterdam, the Netherlands) and the National Women's Health Network (Washington, U.S.A.) are some examples of women's health organizations outside of Canada who share many commonalities with the Canadian women's health movement.

development (Labonté, 1988). Working with consumer organizations across Canada, women's health advocates have raised public awareness about such issues as Depo Provera, DES (diethylstilbestrol), the Dalkon Shield I.U.D. and Toxic Shock Syndrome. Holistic health and alternatives to allopathic medicine have been a strong tenet of some women's health groups in Canada and, in this regard, there has been a good deal of cross-fertilization between the two movements. The women's health movement has shared activities and strategies with the environmental health movement, which has been particularly strong in Nova Scotia and New Brunswick where the issue of pesticide spraying has been a major concern.[151] It shares concerns with the occupational health field, particularly with respect to occupational health issues related to women.

In summary, there has been a maturation of the women's health movement in the last twenty years, characterized by growing links with other movements for change in Canada, along with an increasing ability to work together with government to improve the health of women.

[151] In 1976, women from the centre for Urban and Community Studies at the University of Toronto began a quarterly publication entitled *Women and Environments* which has covered a wide range of health issues since its inception.

Appendix C

Women's Health Activities at the Federal Government Level

Some of the key events and activities related to Health and Welfare Canada's progress towards the development of policy on women's health are summarized below:

1975-1985	The United Nations Decade for Women
1985	The Nairobi Forward-Looking Strategies for the Advancement of Women to the year 2000
1978	W.H.O. World Conference on Primary Health Care, Alma Alta, U.S.S.R. (led to declaration of a global goal to achieve health for all by the year 2000)
1986	Women, Health and Development: PAHO Regional Forward-Looking Strategies
1986	Achieving Health for All: A Framework for Health Promotion, Health and Welfare Canada
1986	Issues and Priorities for Women's Health in Canada: A Key Informant Survey, Health and Welfare Canada
1986	Creation of the Ottawa Charter for Health Promotion at the International Conference on Health Promotion in Ottawa, sponsored by WHO, Health and Welfare Canada and the Canadian Public Health Association
1987	Women and Mental Health in Canada: Strategies for Change. Canadian Mental Health Association
1988	Mental Health for Canadians: Striking a Balance, Health and Welfare Canada
1988	Second International Health Promotion Conference on Healthy Public Policy, Adelaide, Australia (at which representatives from over 60 countries endorsed a "Strategies for Action" statement , recommending that the first priority area for healthy public policy for immediate action was supporting the health of women)

1988	National Symposium on Changing Patterns of Health and Disease in Canadian Women, Ottawa, Health and Welfare Canada (resulting in Forward-Looking Strategies on Healthy Public Policy, Appropriate Health Services and the Enhancement of Coping, Caring and Control)
1988	The Conference of Deputy Ministers of Health creates a Federal / Provincial / Territorial Working Group on Women's Health